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Part 2

SGR REPEAL AND MEDICARE BENEFICIARY ACCESS ACT OF 2013

MARCH 14, 2014.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. CAMP, from the Committee on Ways and Means, submitted the following

R E P O R T

[To accompany H.R. 2810]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2810) to amend title XVIII of the Social Security Act to reform the sustainable growth rate and Medicare payment for physicians' services, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "SGR Repeal and Medicare Beneficiary Access Act of 2013".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Repealing the sustainable growth rate (SGR) and improving medicare payment for physicians' services.
Sec. 3. Priorities and funding for quality measure development.
Sec. 4. Encouraging care management for individuals with chronic care needs.
Sec. 5. Ensuring accurate valuation of services under the physician fee schedule.
Sec. 6. Promoting evidence-based care.
Sec. 7. Empowering beneficiary choices through access to information on physicians' services.
Sec. 8. Expanding claims data availability to improve care.
Sec. 9. Reducing administrative burden and other provisions.

SEC. 2. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

(a) STABILIZING FEE UPDATES.—

(1) REPEAL OF SGR PAYMENT METHODOLOGY.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (d)—

(i) in paragraph (1)(A), by inserting "or a subsequent paragraph" after "paragraph (4)"; and

(ii) in paragraph (4)—

(I) in the heading, by inserting "AND ENDING WITH 2013" after "YEARS BEGINNING WITH 2001"; and

(II) in subparagraph (A), by inserting "and ending with 2013" after "a year beginning with 2001"; and

(B) in subsection (f)—

(i) in paragraph (1)(B), by inserting "through 2013" after "of each succeeding year"; and

(ii) in paragraph (2), by inserting "and ending with 2013" after "beginning with 2000".

(2) UPDATE OF RATES FOR 2014 AND SUBSEQUENT YEARS.—Subsection (d) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new paragraphs:

"(15) UPDATE FOR 2014 THROUGH 2016.—The update to the single conversion factor established in paragraph (1)(C) for each of 2014 through 2016 shall be 0.5 percent.

"(16) UPDATE FOR 2017 THROUGH 2023.—The update to the single conversion factor established in paragraph (1)(C) for each of 2017 through 2023 shall be zero percent.

"(17) UPDATE FOR 2024 AND SUBSEQUENT YEARS.—The update to the single conversion factor established in paragraph (1)(C) for 2024 and each subsequent year shall be—

"(A) for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) for such year, 2 percent; and

"(B) for other items and services, 1 percent.".

(3) MEDPAC REPORTS.—

(A) INITIAL REPORT.—Not later than July 1, 2016, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship between—

(i) physician and other health professional utilization and expenditures (and the rate of increase of such utilization and expenditures) of items and services for which payment is made under section 1848 of the Social Security Act (42 U.S.C. 1395w–4); and

(ii) total utilization and expenditures (and the rate of increase of such utilization and expenditures) under parts A, B, and D of title XVIII of such Act.

Such report shall include a methodology to describe such relationship and the impact of changes in such physician and other health professional practice and service ordering patterns on total utilization and expenditures under parts A, B, and D of such title.

(B) FINAL REPORT.—Not later than July 1, 2020, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship described in subparagraph (A), including the results determined from applying the methodology included in the report submitted under such subparagraph.

(b) CONSOLIDATION OF CERTAIN CURRENT LAW PERFORMANCE PROGRAMS WITH NEW VALUE-BASED PERFORMANCE INCENTIVE PROGRAM.—

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

(A) SUNSETTING SEPARATE MEANINGFUL USE PAYMENT ADJUSTMENTS.—Section 1848(a)(7)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(7)(A)) is amended—

(i) in clause (i), by striking "or any subsequent payment year" and inserting "or 2016";

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by striking "Subject to clause (iii), for" and inserting "For";

(II) in subclause (I), by adding at the end "and";

(III) in subclause (II), by striking "; and" and inserting a period; and

(IV) by striking subclause (III); and

(iii) by striking clause (iii).

(B) CONTINUATION OF MEANINGFUL USE DETERMINATIONS FOR VBP PROGRAM.—Section 1848(o)(2) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)) is amended—

(i) in subparagraph (A), in the matter preceding clause (i)—

(I) by striking "For purposes of paragraph (1), an" and inserting "An"; and

(II) by inserting ", or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year" after "under such subsection for a year"; and

(ii) by adding at the end the following new subparagraph:

"(D) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—With respect to 2017 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a VBP eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year.".

(2) QUALITY REPORTING.—

(A) SUNSETTING SEPARATE QUALITY REPORTING INCENTIVES.—Section 1848(a)(8)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(8)(A)) is amended—

(i) in clause (i), by striking "or any subsequent year" and inserting "or 2016"; and

(ii) in clause (ii)(II), by striking "and each subsequent year".

(B) CONTINUATION OF QUALITY MEASURES AND PROCESSES FOR VBP PROGRAM.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(i) in subsection (k), by adding at the end the following new paragraph:

"(9) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection for purposes of subsection (q).''; and

(ii) in subsection (m)—

(I) by redesignating the paragraph (7) added by section 10327(a) of Public Law 111-148 as paragraph (8); and

(II) by adding at the end the following new paragraph:

"(9) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection for purposes of subsection (q).".

(3) VALUE-BASED PAYMENTS.—

(A) SUNSETTING SEPARATE VALUE-BASED PAYMENTS.—Clause (iii) of section 1848(p)(4)(B) of the Social Security Act (42 U.S.C. 1395w–4(p)(4)(B)) is amended to read as follows:

"(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, but before January 1, 2017, with respect to specific physicians and groups of physicians the Secretary determines appropriate. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2017.".

(B) CONTINUATION OF VALUE-BASED PAYMENT MODIFIER MEASURES FOR VBP PROGRAM.—Section 1848(p) of the Social Security Act (42 U.S.C. 1395w–4(p)) is amended—

(i) in paragraph (2), by adding at the end the following new subparagraph:

"(C) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q)." ; and

(ii) in paragraph (3), by adding at the end the following: "With respect to 2017 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).".

(c) VALUE-BASED PERFORMANCE INCENTIVE PROGRAM.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

"(q) VALUE-BASED PERFORMANCE INCENTIVE PROGRAM.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional value-based performance incentive program (in this subsection referred to as the 'VBP program') under which the Secretary shall—

"(i) develop a methodology for assessing the total performance of each VBP eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

"(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

"(iii) use such composite performance score of the VBP eligible professional for a performance period for a year to make VBP program incentive payments under paragraph (7) to the professional for the year.

"(B) PROGRAM IMPLEMENTATION.—The VBP program shall apply to payments for items and services furnished on or after January 1, 2017.

"(C) VBP ELIGIBLE PROFESSIONAL DEFINED.—

"(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iv), the term 'VBP eligible professional' means—

"(I) for the first and second years for which the VBP program applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)(1)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and

"(II) for the third year for which the VBP program applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I) and such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

"(ii) EXCLUSIONS.—For purposes of clause (i), the term 'VBP eligible professional' does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B))—

"(I) who is a qualifying APM participant (as defined in section 1833(z)(2));

"(II) who, subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the VBP program; or

"(III) who, for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

"(iii) PARTIAL QUALIFYING APM PARTICIPANT.—For purposes of this subparagraph, the term 'partial qualifying APM participant' means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1833(z) for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

"(I) with respect to 2017 and 2018, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

"(II) with respect to 2019 and 2020—

"(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

"(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph were instead references to 40 percent and 20 percent, respectively; and

"(III) with respect to 2021 and subsequent years—

"(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

"(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph were instead references to 50 percent and 20 percent, respectively.

"(iv) SELECTION OF LOW-VOLUME THRESHOLD MEASUREMENT.—The Secretary shall select one of the following low-volume threshold measurements to apply for purposes of clause (ii)(III):

"(I) The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the VBP eligible professional for the performance period involved.

"(II) The minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.

"(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.

"(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a VBP eligible professional until the subsequent year and performance period for such subsequent year.

"(vi) CLARIFICATION.—In the case of items and services furnished during a year by an individual who is not a VBP eligible professional (including pursuant to clauses (ii) and (v)) with respect to a year, in no case shall a reduction under paragraph (6) or a VBP program incentive payment under paragraph (7) apply to such individual for such year.

"(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATION.—In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who for the performance period for such year reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the VBP program, such eligible professional is considered to be a VBP eligible professional with respect to such year.

"(D) APPLICATION TO GROUP PRACTICES.—

"(i) IN GENERAL.—Under the VBP program:

"(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for VBP eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

"(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for VBP eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

"(ii) ENSURING COMPREHENSIVENESS OF GROUP PRACTICE ASSESSMENT.—The process established under clause (i) shall to the extent practicable reflect the full range of items and services furnished by the VBP eligible professionals in the group practice involved.

"(iii) CLARIFICATION.—VBP eligible professionals electing to be a virtual group under paragraph (5)(J) shall not be considered VBP eligible professionals in a group practice for purposes of applying this subparagraph.

"(E) USE OF REGISTRIES.—Under the VBP program, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

"(F) APPLICATION OF CERTAIN PROVISIONS.—In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

"(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

"(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

"(2) MEASURES AND ACTIVITIES UNDER PERFORMANCE CATEGORIES.—

"(A) PERFORMANCE CATEGORIES.—Under the VBP program, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

"(i) Quality.

"(ii) Resource use.

"(iii) Clinical practice improvement activities.

"(iv) Meaningful use of certified EHR technology.

"(B) MEASURES AND ACTIVITIES SPECIFIED FOR EACH CATEGORY.—For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

"(i) QUALITY.—For the performance category described in subparagraph (A)(i), the quality measures established for such period under subsections (k) and (m), including under subsection (m)(3)(E), and the

measures of quality of care established for such period under subsection (p)(2).

"(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r), as appropriate, and, as feasible and applicable, accounting for the cost of covered part D drugs.

"(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities under subcategories specified by the Secretary for such period, which shall include at least the following:

"(I) The subcategory of expanded practice access, which shall include activities such as same day appointments for urgent needs and after hours access to clinician advice.

"(II) The subcategory of population management, which shall include activities such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

"(III) The subcategory of care coordination, which shall include activities such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

"(IV) The subcategory of beneficiary engagement, which shall include activities such as the establishment of care plans for individuals with complex care needs, beneficiary self-management training, and using shared decision-making mechanisms.

"(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

"(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of fewer than 20 professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

"(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

"(C) ADDITIONAL PROVISIONS.—

"(i) EMPHASIZING OUTCOME MEASURES UNDER QUALITY PERFORMANCE CATEGORY.—In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

"(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The Secretary may use measures used for a payment system other than for physicians for purposes of the performance category described in subparagraph (A)(i).

"(iii) GLOBAL AND POPULATION-BASED MEASURES.—The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

"(iv) REQUEST FOR INFORMATION FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders for identifying activities described in such subparagraph and specifying criteria for such activities.

"(v) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY.—In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

"(I) identifying activities described in subparagraph (B)(iii);

"(II) specifying criteria for such activities; and

"(III) determining whether a VBP eligible professional meets such criteria.

"(vi) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PROVIDERS.—In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

"(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically provide services that do not involve face-to-face interaction with a patient; and

"(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to VBP eligible professionals of such professional types or subcategories, in lieu of such a measure or activity, a comparable measure or activity that fulfills the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

"(3) PERFORMANCE STANDARDS.—

"(A) ESTABLISHMENT.—Under the VBP program, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

"(B) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall take into account the following:

"(i) Historical performance standards.

"(ii) Improvement rates.

"(iii) The opportunity for continued improvement.

"(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with the year described in paragraph (1)(B)). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

"(5) COMPOSITE PERFORMANCE SCORE.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and consistent with section 2(g)(2) of the SGR Repeal and Medicare Beneficiary Access Act of 2013, the Secretary shall develop a methodology for assessing the total performance of each VBP eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (in this subsection referred to as the 'composite performance score') for each such professional for each performance period.

"(B) WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), the Secretary—

"(i) may assign different scoring weights (including a weight of 0) for—

"(I) each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

"(II) each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable to the type of eligible professional involved; and

"(ii) with respect to the performance category described in paragraph (2)(A)(i)—

"(I) shall assign a higher scoring weight to outcomes measures than to other measures and increase the scoring weight for outcome measures over time; and

"(II) may assign a higher scoring weight to patient experience measures.

"(C) INCENTIVE TO REPORT; ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—

"(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a VBP eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

"(ii) ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—Under the methodology established under subparagraph (A), the Secretary shall—

"(I) encourage VBP eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology; and

"(II) with respect to a performance period, with respect to a year, for which a VBP eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

"(D) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE.—

"(i) RULE FOR ACCREDITATION.—A VBP eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice pursuant to subsection (b)(8)(B)(i) with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

"(ii) APM PARTICIPATION.—Participation by a VBP eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn such eligible professional one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period. Nothing in the previous sentence shall prevent such professional from earning more than one-half of such highest potential score for such performance period by performing additional activities with respect to such performance category.

"(iii) SUBCATEGORIES.—A VBP eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

"(E) DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in a continuous distribution of performance scores, which shall result in differential payments under paragraph (7).

"(F) ACHIEVEMENT AND IMPROVEMENT.—

"(i) TAKING INTO ACCOUNT IMPROVEMENT.—Beginning with the second year to which the VBP program applies, in addition to the achievement score of a VBP eligible professional, the methodology developed under subparagraph (A)—

"(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), shall take into account the improvement of the professional; and

"(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

"(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT.—Beginning with the fourth year to which the VBP program applies, under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (B) with respect to the achievement score of a VBP eligible professional with respect to a measure or activity specified under paragraph (2)(B) (or with respect to such a measure or activity and with respect to categories described in paragraph (2)(A)) than to any improvement score applied under clause (i) with respect to such measure or activity (or such measure or activity and categories).

"(G) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

"(i) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to clauses (ii) and (iii), the composite performance score shall be determined as follows:

"(I) QUALITY.—

"(aa) IN GENERAL.—Subject to item (bb), 30 percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A).

"(bb) FIRST 2 YEARS AND TEST YEAR.—For the first and second years for which the VBP program applies to payments, 60 percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). With respect to the subsequent year, the percent described in

item (aa) of such score shall be based on performance with respect to such category only for purposes of feedback and 60 percent of such score shall be based on performance with respect to such category for any other purpose under this subsection.

"(II) RESOURCE USE.—

"(aa) IN GENERAL.—Subject to item (bb), 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

"(bb) FIRST 2 YEARS AND TEST YEAR.—For the first and second years for which the VBP program applies to payments, zero percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). With respect to the subsequent year, the percent described in item (aa) of such score shall be based on performance with respect to such category only for purposes of feedback and zero percent of such score shall be based on performance with respect to such category for any other purpose under this subsection.

"(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

"(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

"(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year (or, in the case of a year described in clause (i)(II)(bb), applicable under one or more of subclauses (I) and (III)) shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

"(iii) AUTHORITY TO ADJUST PERCENTAGES FOR QUALITY AND RESOURCE USE.—Other than for a year described in clause (i)(II)(bb), the percentages described in subclauses (I) and (II) of clause (i), including after application of clause (ii), shall be equal.

"(H) RESOURCE USE.—Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

"(I) INCLUSION OF QUALITY MEASURE DATA FROM MULTIPLE PAYERS.—In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by VBP eligible professionals with respect to multiple payers.

"(J) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES.—

"(i) IN GENERAL.—In the case of VBP eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A)—

"(I) the assessment of performance provided under such methodology with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A) that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

"(II) the composite score provided under this paragraph for such performance period with respect to each such performance category for each such VBP eligible professional in such virtual group shall be based on the assessment of the combined performance under subclause (I) for the performance category and performance period.

"(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Secretary shall, in accordance with clause (iii), establish and have in place a proc-

ess to allow an individual VBP eligible professional or a group practice consisting of not more than 10 VBP eligible professionals to elect, with respect to a performance period for a year, for such individual VBP eligible professional or all such VBP eligible professionals in such group practice, respectively, to be a virtual group under this subparagraph with at least one other such individual VBP eligible professional or group practice making such an election.

"(iii) REQUIREMENTS.—The process under clause (ii) shall provide that—

"(I) an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period; and

"(II) a practice described in such clause, and each VBP eligible professional in such practice, may elect to be in no more than one virtual group for a performance period.

"(6) FUNDING FOR VBP PROGRAM INCENTIVE PAYMENTS.—

"(A) TOTAL AMOUNT FOR INCENTIVE PAYMENTS.—The total amount for VBP program incentive payments under paragraph (7) for all VBP eligible professionals for a year shall be equal to the total amount of the performance funding pool for all VBP eligible professionals under subparagraph (B) for such year, as estimated by the Secretary.

"(B) PERFORMANCE FUNDING POOL.—

"(i) IN GENERAL.—In the case of items and services furnished by a VBP eligible professional during a year (beginning with 2017), the otherwise applicable fee schedule amount (as defined in clause (iii)) with respect to such items and services and eligible professional for such year shall be reduced by the applicable percent under clause (ii). The total amount of such reductions for a year shall be referred to in this subsection as the 'performance funding pool' for such year.

"(ii) APPLICABLE PERCENT DEFINED.—For purposes of clause (i), the term 'applicable percent' means—

"(I) for 2017, 4 percent;

"(II) for 2018, 6 percent;

"(III) for 2019, 8 percent;

"(IV) for 2020, 10 percent; and

"(V) for 2021 and subsequent years, a percent specified by the Secretary (but in no case less than 10 percent or more than 12 percent).

"(iii) OTHERWISE APPLICABLE FEE SCHEDULE AMOUNT.—For purposes of this subparagraph and paragraph (7), the term 'otherwise applicable fee schedule amount' means, with respect to items and services furnished by a VBP eligible professional during a year, the fee schedule amount for such items and services and year that would otherwise apply (without application of this subparagraph or paragraph (7)) with respect to such eligible professional under subsection (b), after application of subsection (a)(3), or under another fee schedule under this part.

"(7) VBP PROGRAM INCENTIVE PAYMENTS.—

"(A) VBP PROGRAM INCENTIVE PAYMENT ADJUSTMENT FACTOR.—Consistent with section 2(g)(2) of the SGR Repeal and Medicare Beneficiary Access Act of 2013, the Secretary shall specify a VBP program incentive payment adjustment factor for each VBP eligible professional for a year. Such VBP program incentive payment adjustment factor for a VBP eligible professional for a year shall be determined—

"(i) by the composite performance score of the eligible professional for such year;

"(ii) in a manner such that the adjustment factors specified under this subparagraph for a year results in differential payments under this paragraph reflecting the full range of the distribution of composite performance scores of VBP eligible professionals determined under paragraph (5)(E) for such year, with such professionals having higher composite performance scores receiving higher payment; and

"(iii) in a manner such that the adjustment factors specified under this subparagraph for a year—

"(I) does not result in a payment reduction for such year by an amount that exceeds the applicable percent described in paragraph (6)(B)(ii) for such year; and

"(II) does not result in a payment increase for such year by an amount that exceeds the applicable percent described in paragraph (6)(B)(ii) for such year.

"(B) CALCULATION OF VBP PROGRAM INCENTIVE PAYMENT AMOUNTS.—The VBP program incentive payment amount with respect to items and services furnished by a VBP eligible professional during a year shall be equal to the difference between—

"(i) the product of—

"(I) the VBP program incentive payment adjustment factor determined under subparagraph (A) for such VBP eligible professional for such year; and

"(II) the otherwise applicable fee schedule amount (as defined in paragraph (6)(B)(iii)) with respect to such items and services and eligible professional for such year; and

"(ii) the otherwise applicable fee schedule amount, as reduced under paragraph (6)(B), with respect to such items and services, eligible professional, and year.

The application of the preceding sentence may result in the VBP program incentive payment amount being 0.0 with respect to an item or service furnished by a VBP eligible professional.

"(C) APPLICATION OF VBP PROGRAM INCENTIVE PAYMENT AMOUNT.—In the case of items and services furnished by a VBP eligible professional during a year (beginning with 2017), the otherwise applicable fee schedule amount, as reduced under paragraph (6)(B), with respect to such items and services and eligible professional for such year shall be increased, if applicable, by the VBP program incentive payment amount determined under subparagraph (B) with respect to such items and services, professional, and year.

"(D) BUDGET NEUTRALITY.—In specifying the VBP program incentive payment adjustment factor for each VBP eligible professional for a year under subparagraph (A), the Secretary shall ensure that the total amount of VBP program incentive payment amounts under this paragraph for all VBP eligible professionals in a year shall be equal to the performance funding pool for such year under paragraph (6), as estimated by the Secretary.

"(8) ANNOUNCEMENT OF RESULT OF ADJUSTMENTS.—Under the VBP program, the Secretary shall, not later than 60 days prior to the year involved, make available to each VBP eligible professional the VBP program incentive payment adjustment factor under paragraph (7) and the payment reduction under paragraph (6) applicable to the eligible professional for items and services furnished by the professional in such year. The Secretary may include such information in the confidential feedback under paragraph (13).

"(9) NO EFFECT IN SUBSEQUENT YEARS.—The VBP program incentive payment under paragraph (7) and the payment reduction under paragraph (6) shall each apply only with respect to the year involved, and the Secretary shall not take into account such VBP program incentive payment or payment reduction in making payments to a VBP eligible professional under this part in a subsequent year.

"(10) PUBLIC REPORTING.—

"(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website under subsection (t) the following:

"(i) Information regarding the performance of VBP eligible professionals under the VBP program, which—

"(I) shall include the composite score for each such VBP eligible professional and the performance of each such VBP eligible professional with respect to each performance category; and

"(II) may include the performance of each such VBP eligible professional with respect to each measure or activity specified in paragraph (2)(B).

"(ii) The names of eligible professionals in eligible alternative payment models (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

"(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

"(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

"(D) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the VBP program, including the range of composite scores for all VBP eligible professionals and the range of the performance of all VBP eligible professionals with respect to each performance category.

"(11) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the VBP program, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (7). Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

"(12) TECHNICAL ASSISTANCE TO SMALL PRACTICES AND PRACTICES IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

"(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to VBP eligible professionals in practices of fewer than 20 professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of the Public Health Service Act), or practices with low composite scores) with respect to—

"(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

"(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C).

"(B) FUNDING FOR IMPLEMENTATION.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of $50,000,000 for each of fiscal years 2014 through 2018. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

"(13) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

"(A) PERFORMANCE FEEDBACK.—

"(i) IN GENERAL.—Beginning July 1, 2015, the Secretary—

"(I) shall make available timely (such as quarterly) confidential feedback to each VBP eligible professional on the performance of such professional with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

"(II) may make available confidential feedback to each such professional on the performance of such professional with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

"(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. The Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (m)(3)(E)).

"(iii) USE OF DATA.—For purposes of clause (i), the Secretary may use data, with respect to a VBP eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

"(iv) DISCLOSURE EXEMPTION.—Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5, United States Code.

"(v) RECEIPT OF INFORMATION.—The Secretary may use the mechanisms established under clause (ii) to receive information from professionals, such as information with respect to this subsection.

"(B) ADDITIONAL INFORMATION.—

"(i) IN GENERAL.—Beginning July 1, 2016, the Secretary shall make available to each VBP eligible professional information, with respect to individuals who are patients of such VBP eligible professional, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information shall be made available under the previous sentence to such VBP eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such infor-

mation shall be made available in accordance with the same or similar terms as data are made available to accountable care organizations under section 1899, including a beneficiary opt-out.

"(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

"(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title and that are furnished to individuals, who are patients of a VBP eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

"(II) Historical averages (and other measures of the distribution if appropriate) of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary) for care episodes for such period.

"(14) REVIEW.—

"(A) TARGETED REVIEW.—The Secretary shall establish a process under which a VBP eligible professional may seek an informal review of the calculation of the VBP program incentive payment adjustment factor applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (7) with respect to a year (other than with respect to the calculation of such eligible professional's VBP program incentive payment adjustment factor for such year) after the factors determined in subparagraph (A) of such paragraph have been determined for such year.

"(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(i) The methodology used to determine the amount of the VBP program incentive payment adjustment factor under paragraph (7) and the determination of such amount.

"(ii) The determination of the amount of funding available for such VBP program incentive payments under paragraph (6)(A) and the payment reduction under paragraph (6)(B)(i).

"(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

"(iv) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (10).

"(v) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.".

(2) GAO REPORTS.—

(A) EVALUATION OF ELIGIBLE PROFESSIONAL VBP PROGRAM.—Not later than October 1, 2018, and October 1, 2021, the Comptroller General of the United States shall submit to Congress a report evaluating the eligible professional value-based performance incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by paragraph (1). Such report shall—

(i) examine the distribution of the performance and incentive payments for VBP eligible professionals (as defined in subsection (q)(1)(C) of such section) under such program, and patterns relating to such performance and incentive payments, including based on type of provider, practice size, geographic location, and patient mix; and

(ii) provide recommendations for improving such program.

(B) STUDY TO EXAMINE ALIGNMENT OF QUALITY MEASURES USED IN PUBLIC AND PRIVATE PROGRAMS.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that—

(i) compares the similarities and differences in the use of quality measures under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare Advantage program under part C of such title, and private payer arrangements; and

(ii) makes recommendations on how to reduce the administrative burden involved in applying such quality measures.

(3) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the amendments made by this section, the Secretary of Health and Human Services shall provide for the transfer of $50,000,000 from the Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Program Management Account for each of the fiscal years 2014 through 2017. Amounts transferred under this paragraph shall be available until expended.

(d) IMPROVING QUALITY REPORTING FOR COMPOSITE SCORES.—

(1) CHANGES FOR GROUP REPORTING OPTION.—

(A) IN GENERAL.—Section 1848(m)(3)(C)(ii)) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended by inserting "and, for 2014 and subsequent years, may provide" after "shall provide".

(B) CLARIFICATION OF QUALIFIED CLINICAL DATA REGISTRY REPORTING TO GROUP PRACTICES.—Section 1848(m)(3)(D) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is amended by inserting "and, for 2015 and subsequent years, subparagraph (A) or (C)" after "subparagraph (A)".

(2) CHANGES FOR MULTIPLE REPORTING PERIODS AND ALTERNATIVE CRITERIA FOR SATISFACTORY REPORTING.—Section 1848(m)(5)(F)) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)(F)) is amended—

(A) by striking "and subsequent years" and inserting "through reporting periods occurring in 2013"; and

(B) by inserting "and, for reporting periods occurring in 2014 and subsequent years, the Secretary may establish" following "shall establish".

(3) PHYSICIAN FEEDBACK PROGRAM REPORTS SUCCEEDED BY REPORTS UNDER VBP PROGRAM.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended by adding at the end the following new paragraph:

"(11) REPORTS ENDING WITH 2016.—Reports under the Program shall not be provided after December 31, 2016. See subsection (q)(13) for reports beginning with 2017.".

(4) COORDINATION WITH SATISFYING MEANINGFUL EHR USE CLINICAL QUALITY MEASURE REPORTING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(iii)) is amended by inserting "and subsection (q)(5)(C)(ii)(II)" after "Subject to subparagraph (B)(ii)".

(e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

(1) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

"(1) PAYMENT INCENTIVE.—

"(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2017 and ending with 2022 and for which the professional is a qualifying APM participant, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the payment amount for the covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases where payment for covered professional services furnished by a qualifying APM participant in an alternative payment model is made to an entity participating in the alternative payment model rather than directly to the qualifying APM participant.

"(B) FORM OF PAYMENT.—Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

"(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

"(D) COORDINATION.—The amount of the additional payment for an item or service under this subsection or subsection (m) shall be determined without regard to any additional payment for the item or service under subsection (m) and this subsection, respectively. The amount of the additional payment for an item or service under this subsection or subsection (x) shall

be determined without regard to any additional payment for the item or service under subsection (x) and this subsection, respectively. The amount of the additional payment for an item or service under this subsection or subsection (y) shall be determined without regard to any additional payment for the item or service under subsection (y) and this subsection, respectively.

"(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term 'qualifying APM participant' means the following:

"(A) 2017 AND 2018.—With respect to 2017 and 2018, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

"(B) 2019 AND 2020.—With respect to 2019 and 2020, an eligible professional described in either of the following clauses:

"(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

"(ii) COMBINATION ALL-PAYER AND MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional—

"(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

"(aa) payments described in clause (i); and

"(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of law),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

"(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services; and

"(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

"(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

"(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made under an eligible alternative payment model; and

"(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

"(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

"(bb) certified EHR technology is used; and

"(cc) the eligible professional bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures.

"(C) BEGINNING IN 2021.—With respect to 2021 and each subsequent year, an eligible professional described in either of the following clauses:

"(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by

such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

"(ii) COMBINATION ALL-PAYER AND MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional—

"(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

"(aa) payments described in clause (i); and

"(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of law),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

"(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services; and

"(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

"(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

"(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made under an eligible alternative payment model; and

"(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

"(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

"(bb) certified EHR technology is used; and

"(cc) the eligible professional bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures.

"(2) ADDITIONAL DEFINITIONS.—In this subsection:

"(A) COVERED PROFESSIONAL SERVICES.—The term 'covered professional services' has the meaning given that term in section 1848(k)(3)(A).

"(B) ELIGIBLE PROFESSIONAL.—The term 'eligible professional' has the meaning given that term in section 1848(k)(3)(B).

"(C) ALTERNATIVE PAYMENT MODEL (APM).—The term 'alternative payment model' means any of the following:

"(i) A model under section 1115A (other than a health care innovation award).

"(ii) An accountable care organization under section 1899.

"(iii) A demonstration under section 1866C.

"(iv) A demonstration required by Federal law.

"(D) ELIGIBLE ALTERNATIVE PAYMENT MODEL (APM).—

"(i) IN GENERAL.—The term 'eligible alternative payment model' means, with respect to a year, an alternative payment model—

"(I) that requires use of certified EHR technology (as defined in subsection (o)(4));

"(II) that provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

"(III) that satisfies the requirement described in clause (ii).

"(ii) ADDITIONAL REQUIREMENT.—For purposes of clause (i)(III), the requirement described in this clause, with respect to a year and an alternative payment model, is that the alternative payment model—

"(I) is one in which one or more entities bear financial risk for monetary losses under such model that are in excess of a nominal amount; or

"(II) is a medical home expanded under section 1115A(c).

"(3) LIMITATION.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

"(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an alternative payment model is an eligible alternative payment model under paragraph (3)(D).

"(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.".

(2) COORDINATION CONFORMING AMENDMENTS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is further amended—

(A) in subsection (x)(3), by adding at the end the following new sentence: "The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively."; and

(B) in subsection (y)(3), by adding at the end the following new sentence: "The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.".

(3) ENCOURAGING DEVELOPMENT AND TESTING OF CERTAIN MODELS.—Section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

(A) in subparagraph (B), by adding at the end the following new clauses:

"(xxi) Focusing primarily on physicians' services (as defined in section 1848(j)(3)) furnished by physicians who are not primary care practitioners.

"(xxii) Focusing on practices of fewer than 20 professionals."; and

(B) in subparagraph (C)(viii), by striking "other public sector or private sector payers" and inserting "other public sector payers, private sector payers, or Statewide payment models".

(f) STUDY AND REPORT ON FRAUD RELATED TO ALTERNATIVE PAYMENT MODELS UNDER THE MEDICARE PROGRAM.—

(1) STUDY.—The Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a study that—

(A) examines the applicability of the Federal fraud prevention laws to items and services furnished under title XVIII of the Social Security Act for which payment is made under an alternative payment model (as defined in section 1833(z)(3)(C) of such Act (42 U.S.C. 1395l(z)(3)(C)));

(B) identifies aspects of such alternative payment models that are vulnerable to fraudulent activity; and

(C) examines the implications of waivers to such laws granted in support of such alternative payment models, including under any potential expansion of such models.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1). Such report shall include recommendations for actions to be taken to reduce the vulnerability of such alternative payment models to fraudulent activity. Such report also shall include, as appropriate, recommendations of the Inspector General for changes in Federal fraud prevention laws to reduce such vulnerability.

(g) IMPROVING PAYMENT ACCURACY.—

(1) STUDIES AND REPORTS OF EFFECT OF CERTAIN INFORMATION ON QUALITY AND RESOURCE USE .—

(A) STUDY USING EXISTING MEDICARE DATA.—

(i) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall conduct a study that examines the effect of individuals' socioeconomic status on quality and resource use outcome measures for individuals under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). The study shall use information collected on such individuals in carrying out such program, such as urban and rural location, eligibility for Medicaid (recognizing and accounting for varying Medicaid eligibility across States), and eligibility for benefits

under the supplemental security income (SSI) program. The Secretary shall carry out this paragraph acting through the Assistant Secretary for Planning and Evaluation.

(ii) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under clause (i).

(B) STUDY USING OTHER DATA.—

(i) STUDY.—The Secretary shall conduct a study that examines the impact of risk factors, such as those described in section 1848(p)(3) of the Social Security Act (42 U.S.C. 1395w–4(p)(3)), race, health literacy, limited English proficiency (LEP), and patient activation, on quality and resource use outcome measures under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). In conducting such study the Secretary may use existing Federal data and collect such additional data as may be necessary to complete the study.

(ii) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under clause (i).

(C) EXAMINATION OF DATA IN CONDUCTING STUDIES.—In conducting the studies under subparagraphs (A) and (B), the Secretary shall examine what non-Medicare data sets, such as data from the American Community Survey (ACS), can be useful in conducting the types of studies under such paragraphs and how such data sets that are identified as useful can be coordinated with Medicare administrative data in order to improve the overall data set available to do such studies and for the administration of the Medicare program.

(D) RECOMMENDATIONS TO ACCOUNT FOR INFORMATION IN PAYMENT ADJUSTMENT MECHANISMS.—If the studies conducted under subparagraphs (A) and (B) find a relationship between the factors examined in the studies and quality and resource use outcome measures, then the Secretary shall also provide recommendations for how the Centers for Medicare & Medicaid Services should—

(i) obtain access to the necessary data (if such data is not already being collected) on such factors, including recommendations on how to address barriers to the Centers in accessing such data; and

(ii) account for such factors in determining payment adjustments based on quality and resource use outcome measures under the eligible professional value-based performance incentive program under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)) and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(E) FUNDING.—There are hereby appropriated from the Federal Supplemental Medical Insurance Trust Fund to the Secretary to carry out this paragraph $6,000,000, to remain available until expended.

(2) CMS ACTIVITIES.—

(A) HIERARCHAL CONDITION CATEGORY (HCC) IMPROVEMENT.—Taking into account the relevant studies conducted and recommendations made in reports under paragraph (1), the Secretary, on an ongoing basis, shall estimate how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, shall incorporate information from quality and resource use outcome measurement (including care episode and patient condition groups) into the eligible professional value-based performance incentive program under section 1848(q) of the Social Security Act and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(B) ACCOUNTING FOR OTHER FACTORS IN PAYMENT ADJUSTMENT MECHANISMS.—

(i) IN GENERAL.—Taking into account the studies conducted and recommendations made in reports under paragraph (1), the Secretary shall account for identified factors (other than those applied under subparagraph (A)) with an effect on quality and resource use outcome measures when determining payment adjustments under the eligible professional value-based performance incentive program under section 1848(q) of the Social Security Act and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(ii) ACCESSING DATA.—The Secretary shall collect or otherwise obtain access to the data necessary to carry out this paragraph through existing and new data sources.

(iii) PERIODIC ANALYSES.—The Secretary shall carry out periodic analyses, at least every 3 years, based on the factors referred to in clause (i) so as to monitor changes in possible relationships.

(C) FUNDING.—There are hereby appropriated from the Federal Supplemental Medical Insurance Trust Fund to the Secretary to carry out this paragraph $10,000,000, to remain available until expended.

(3) STRATEGIC PLAN FOR ACCESSING RACE AND ETHNICITY DATA.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of carrying out the eligible professional value-based performance incentive program under section 1848(q) of the Social Security Act and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(h) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (c), is further amended by adding at the end the following new subsection:

"(r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

"(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the value-based performance incentive program under subsection (q) and alternative payment models under section 1833(z), the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

"(2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

"(A) IN GENERAL.—In order to classify similar patients into distinct care episode groups and distinct patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

"(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 60 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

"(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 60 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

"(i) distinct care episode groups; and

"(ii) distinct patient condition groups.

"(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

"(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

"(I) establish distinct care episode groups and distinct patient condition groups, which account for at least an estimated two-thirds of expenditures under parts A and B; and

"(II) assign codes to such groups.

"(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

"(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization is anticipated or occurs, and the principal procedures or services planned or furnished; and

"(II) other factors determined appropriate by the Secretary.

"(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

"(I) the patient's clinical history at the time of each medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

"(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under sec-

tion 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

"(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 120 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

"(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

"(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 120 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

"(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2016), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

"(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

"(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

"(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

"(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

"(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

"(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

"(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

"(v) furnishes items and services only as ordered by another physician or practitioner.

"(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

"(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding

the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

"(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 120 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

"(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2016), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

"(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2016, shall, as determined appropriate by the Secretary, include—

"(A) applicable codes established under paragraphs (2) and (3); and

"(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

"(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

"(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall—

"(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

"(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

"(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients), as the Secretary determines appropriate.

"(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

"(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

"(ii) use the claims data experience of such patients by care episode codes—

"(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

"(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

"(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

"(i) shall use per patient total allowed amounts for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

"(ii) may, as determined appropriate, use other measures of allowed amounts (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

"(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments

the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

"(6) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

"(A) care episode and patient condition groups and codes established under paragraph (2);

"(B) patient relationship categories and codes established under paragraph (3); and

"(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

"(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

"(8) DEFINITIONS.—In this section:

"(A) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r)(1).

"(B) APPLICABLE PRACTITIONER.—The term 'applicable practitioner' means—

"(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)); and

"(ii) beginning January 1, 2017, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

"(9) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.".

SEC. 3. PRIORITIES AND FUNDING FOR QUALITY MEASURE DEVELOPMENT.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (h) of section 2, is further amended by inserting at the end the following new subsection:

"(s) PRIORITIES AND FUNDING FOR QUALITY MEASURE DEVELOPMENT.—

"(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

"(A) DRAFT MEASURE DEVELOPMENT PLAN.—

"(i) DRAFT PLAN.—

"(I) IN GENERAL.—Not later than October 1, 2014, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions.

"(II) REQUIREMENT.—Such plan shall address how measures used by private payers and integrated delivery systems could be incorporated under such subsection.

"(ii) CONSIDERATION.—In developing the draft plan under subparagraph (A), the Secretary shall consider—

"(I) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities; and

"(II) whether measures are applicable across health care settings.

"(iii) PRIORITIES.—In developing the draft plan under subparagraph (A), the Secretary shall give priority to the following types of measures:

"(I) Outcome measures including patient reported outcome and functional status measures.

"(II) Patient experience measures.

"(III) Care coordination measures.

"(IV) Measures of appropriate use of services, including measures of over use.

"(iv) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term 'applicable provisions' means the following provisions:

"(I) Subsection (q)(2)(B)(i).

"(II) Section 1833(z)(2)(C).

"(B) STAKEHOLDER INPUT.—The Secretary shall accept through December 1, 2014, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

"(C) OPERATIONAL MEASURE DEVELOPMENT PLAN.—Not later than February 1, 2015, taking into account the comments received under subparagraph (B), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under subsection (q)(2)(A)(i).

"(2) CONTRACTS AND OTHER ARRANGEMENTS FOR QUALITY MEASURE DEVELOPMENT.—

"(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding quality measures for application under the applicable provisions. Such entities may include physician specialty societies and other practitioner organizations.

"(B) PRIORITIZATION.—

"(i) IN GENERAL.—In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(A)(iii).

"(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider whether such measures would be electronically specified.

"(3) ANNUAL REPORT BY THE SECRETARY.—

"(A) IN GENERAL.—Not later than February 1, 2016, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

"(B) REQUIREMENTS.—Each report submitted pursuant to paragraph (1) shall include the following:

"(i) A description of the Secretary's efforts to implement this subsection.

"(ii) With respect to the measures developed during the previous year—

"(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

"(II) the name of each measure developed;

"(III) the name of the developer and steward of each measure;

"(IV) with respect to each type of measure, an estimate of the total amount expended under this title to develop all measures of such type; and

"(V) whether the measure would be electronically specified.

"(iii) With respect to measures in development at the time of the report—

"(I) the information described in clause (ii), if available; and

"(II) a timeline for completion of the development of such measures.

"(iv) An update on the progress in developing the types of measures described in paragraph (1)(A)(iii), including a description of issues affecting such progress.

"(v) A list of quality topics and concepts that are being considered for development of measures and the rationale for the selection of topics and concepts including their relationship to gap analyses.

"(vi) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

"(vii) Other information the Secretary determines to be appropriate.

"(4) STAKEHOLDER INPUT.—With respect to measures applicable under the applicable provisions, the Secretary shall seek stakeholder input with respect to—

"(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(A)(iii);

"(B) prioritizing quality measure development to address such gaps; and

"(C) other areas related to quality measure development determined appropriate by the Secretary.

"(5) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2014 through 2018. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2021.".

SEC. 4. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.

Section 1848(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) is amended by adding at the end the following new paragraph:

"(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

"(A) IN GENERAL.—In order to encourage the management of care by an applicable provider (as defined in subparagraph (B)) for individuals with chronic care needs the Secretary shall—

"(i) establish one or more HCPCS codes for chronic care management services for such individuals; and

"(ii) subject to subparagraph (D), make payment (as the Secretary determines to be appropriate) under this section for such management services furnished on or after January 1, 2015, by an applicable provider.

"(B) APPLICABLE PROVIDER DEFINED.—For purposes of this paragraph, the term 'applicable provider' means a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), or clinical nurse specialist (as defined in section 1861(aa)(5)(B)) who furnishes services as part of a patient-centered medical home or a comparable specialty practice that—

"(i) is recognized as such a medical home or comparable specialty practice by an organization that is recognized by the Secretary for purposes of such recognition as such a medical home or practice; or

"(ii) meets such other comparable qualifications as the Secretary determines to be appropriate.

"(C) BUDGET NEUTRALITY.—The budget neutrality provision under subsection (c)(2)(B)(ii)(II) shall apply in establishing the payment under subparagraph (A)(ii).

"(D) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

"(i) make payment to only one applicable provider for such services furnished to an individual during a period;

"(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services (such as in the case of hospice care or home health services); and

"(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.".

SEC. 5. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

"(M) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

"(i) COLLECTION OF INFORMATION.—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

"(ii) USE OF INFORMATION.—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

"(iii) TYPES OF INFORMATION.—The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

"(I) Time involved in furnishing services.

"(II) Amounts and types of practice expense inputs involved with furnishing services.

"(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

"(IV) Overhead and accounting information for practices of physicians and other suppliers.

"(V) Any other element that would improve the valuation of services under this section.

"(iv) INFORMATION COLLECTION MECHANISMS.—Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

"(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

"(II) Surgical logs, billing systems, or other practice or facility records.

"(III) Electronic health records.

"(IV) Any other mechanism determined appropriate by the Secretary.

"(v) TRANSPARENCY OF USE OF INFORMATION.—

"(I) IN GENERAL.—Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

"(II) THRESHOLDS FOR USE.—The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

"(III) DISCLOSURE OF INFORMATION.—The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

"(vi) INCENTIVE TO PARTICIPATE.—The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

"(vii) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information collected or obtained under this subparagraph.

"(viii) DEFINITION OF ELIGIBLE PROFESSIONAL.—In this subparagraph, the term 'eligible professional' has the meaning given such term in subsection (k)(3)(B).

"(ix) FUNDING.—For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.".

(2) LIMITATION ON REVIEW.—Section 1848(i)(1) of the Social Security Act (42 U.S.C. 1395w–4(i)(1)) is amended—

(A) in subparagraph (D), by striking "and" at the end;

(B) in subparagraph (E), by striking the period at the end and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).".

(b) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

"(N) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).".

(c) REVISED AND EXPANDED IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—Section 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(K)(ii)) is amended to read as follows:

"(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued codes pursuant to clause

(i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

"(I) Codes that have experienced the fastest growth.

"(II) Codes that have experienced substantial changes in practice expenses.

"(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

"(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

"(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

"(VI) Codes that have not been subject to review since implementation of the fee schedule.

"(VII) Codes that account for the majority of spending under the physician fee schedule.

"(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

"(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

"(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

"(XI) Codes for which there may be anomalies in relative values within a family of codes.

"(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

"(XIII) Codes with high intra-service work per unit of time.

"(XIV) Codes with high practice expense relative value units.

"(XV) Codes with high cost supplies.

"(XVI) Codes as determined appropriate by the Secretary.".

(d) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

"(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2015 through 2018, the following shall apply:

"(i) DETERMINATION OF NET REDUCTION IN EXPENDITURES.—For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

"(ii) BUDGET NEUTRAL REDISTRIBUTION OF FUNDS IF TARGET MET AND COUNTING OVERAGES TOWARDS THE TARGET FOR THE SUCCEEDING YEAR.—If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

"(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

"(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of determining whether the target has or has not been met under this subparagraph with respect to that year.

"(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2015.

"(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

"(I) the target for the year; and

"(II) the estimated net reduction in expenditures determined under clause (i) for the year.

"(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent of the estimated amount of expenditures under the fee schedule under this section for the year.".

(2) CONFORMING AMENDMENT.—Section 1848(c)(2)(B)(v) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(v)) is amended by adding at the end the following new subclause:

"(VIII) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2015, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).".

(e) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—

(1) IN GENERAL.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w–4(c)) is amended by adding at the end the following new paragraph:

"(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2015, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.".

(2) CONFORMING AMENDMENTS.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)(ii)(I), by striking "subclause (II)" and inserting "subclause (II) and paragraph (7)"; and

(B) in subparagraph (K)(iii)(VI)—

(i) by striking "provisions of subparagraph (B)(ii)(II)" and inserting "provisions of subparagraph (B)(ii)(II) and paragraph (7)"; and

(ii) by striking "under subparagraph (B)(ii)(II)" and inserting "under subparagraph (B)(ii)(I)".

(f) AUTHORITY TO SMOOTH RELATIVE VALUES WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)) is amended—

(1) in each of clauses (i) and (iii), by striking "the service" and inserting "the service or group of services" each place it appears; and

(2) in the first sentence of clause (ii), by inserting "or group of services" before the period.

(g) GAO STUDY AND REPORT ON RELATIVE VALUE SCALE UPDATE COMMITTEE.—

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the "Comptroller General") shall conduct a study of the processes used by the Relative Value Scale Update Committee (RUC) to provide recommendations to the Secretary of Health and Human Services regarding relative values for specific services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1).

(h) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

(1) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w–4(e)) is amended by adding at the end the following new paragraph:

"(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

"(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

"(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

"(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

"(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

"(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic

index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

"(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

"(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

"(I) for 2017, is 5/6; and

"(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

"(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

"(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

"(D) TRANSITION AREA DEFINED.—In this paragraph, the term 'transition area' means each of the following fee schedule areas for 2013:

"(i) The rest-of-State payment locality.

"(ii) Payment locality 3.

"(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.".

(2) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)) is amended by striking "The term" and inserting "Except as provided in subsection (e)(6)(D), the term".

SEC. 6. PROMOTING EVIDENCE-BASED CARE.

(a) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

"(1) PROGRAM ESTABLISHED.—

"(A) IN GENERAL.—The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

"(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term 'appropriate use criteria' means criteria to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition. To the extent feasible, such criteria shall be evidence-based.

"(C) APPLICABLE IMAGING SERVICE DEFINED.—In this subsection, the term 'applicable imaging service' means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

"(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

"(ii) there are one or more qualified clinical decision support mechanisms listed under paragraph (3)(C); and

"(iii) one or more of such mechanisms is available free of charge.

"(D) APPLICABLE SETTING DEFINED.—In this subsection, the term 'applicable setting' means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other outpatient setting determined appropriate by the Secretary.

"(E) ORDERING PROFESSIONAL DEFINED.—In this subsection, the term 'ordering professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who orders an applicable imaging service for an individual.

"(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term 'furnishing professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service for an individual.

"(2) ESTABLISHMENT OF APPLICABLE APPROPRIATE USE CRITERIA.—

"(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other entities.

"(B) CONSIDERATIONS.—In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

"(i) have stakeholder consensus;

"(ii) have been determined to be scientifically valid and are evidence based; and

"(iii) are in the public domain.

"(C) REVISIONS.—The Secretary shall periodically update and revise (as appropriate) such specification of applicable appropriate use criteria.

"(D) TREATMENT OF MULTIPLE APPLICABLE APPROPRIATE USE CRITERIA.—In the case where the Secretary determines that more than one appropriate use criteria applies with respect to an applicable imaging service, the Secretary shall specify one or more applicable appropriate use criteria under this paragraph for the service.

"(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(i) IN GENERAL.—The Secretary shall specify one or more qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

"(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, and other stakeholders in specifying mechanisms under this paragraph.

"(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

"(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1848(o)(4)).

"(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

"(III) Use of a clinical decision support mechanism established by the Secretary.

"(B) QUALIFIED CLINICAL DECISION SUPPORT MECHANISMS.—

"(i) IN GENERAL.—For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

"(ii) REQUIREMENTS.—The requirements described in this clause are the following:

"(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

"(II) In the case where there are more than one applicable appropriate use criteria specified under such paragraph for an applicable imaging service, the mechanism indicates the criteria that it uses for the service.

"(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

"(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

"(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

"(VI) The mechanism meets privacy and security standards under applicable provisions of law.

"(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

"(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(i) INITIAL LIST.—Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

"(ii) PERIODIC UPDATING OF LIST.—The Secretary shall periodically update the list of qualified clinical decision support mechanisms specified under this paragraph.

"(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(A) CONSULTATION BY ORDERING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

"(i) consult with a qualified decision support mechanism listed under paragraph (3)(C); and

"(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

"(B) REPORTING BY FURNISHING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), payment for such service may only be made if the claim for the service includes the following:

"(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

"(ii) Information regarding—

"(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

"(II) whether the service ordered would not adhere to such criteria; or

"(III) whether such criteria was not applicable to the service ordered.

"(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

"(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

"(i) EMERGENCY SERVICES.—An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1867(e)(1)).

"(ii) INPATIENT SERVICES.—An applicable imaging service ordered for an inpatient and for which payment is made under part A.

"(iii) ALTERNATIVE PAYMENT MODELS.—An applicable imaging service ordered by an ordering professional with respect to an individual attributed to an alternative payment model (as defined in section 1833(z)(3)(C)).

"(iv) SIGNIFICANT HARDSHIP.—An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

"(D) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term 'applicable payment system' means the following:

"(i) The physician fee schedule established under section 1848(b).

"(ii) The prospective payment system for hospital outpatient department services under section 1833(t).

"(iii) The ambulatory surgical center payment systems under section 1833(i).

"(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

"(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on a periodic basis

(which may be annually), ordering professionals who are outlier ordering professionals.

"(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

"(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

"(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

"(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

"(D) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

"(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

"(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

"(B) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.".

(2) CONFORMING AMENDMENT.—Section 1833(t)(16) of the Social Security Act (42 U.S.C. 1395l(t)(16)) is amended by adding at the end the following new subparagraph:

"(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(p).".

(b) ESTABLISHMENT OF APPROPRIATE USE PROGRAM FOR OTHER PART B SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by subsection (a), is amended by adding at the end the following new subsection:

"(q) ESTABLISHMENT OF APPROPRIATE USE PROGRAM FOR OTHER PART B SERVICES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary may establish an appropriate use program for services under this part (other than applicable imaging services under subsection (p)) using a process similar to the process under such subsection.

"(B) REQUIREMENTS.—In determining whether to establish a program under subparagraph (A), the Secretary shall take into consideration—

"(i) the implementation of appropriate use criteria for applicable imaging services under subsection (p); and

"(ii) the report under paragraph (2).

"(C) INPUT FROM STAKEHOLDERS IN ADVANCE OF RULEMAKING.—Before issuing a notice of proposed rulemaking to establish a program under subparagraph (A), the Secretary shall issue an advance notice of proposed rulemaking.

"(2) REPORT ON EXPERIENCE OF IMAGING APPROPRIATE USE CRITERIA PROGRAM.—Not later than 18 months after the date of the enactment of this subsection, the Comptroller General of the United States shall submit to Congress a report that includes a description of the extent to which appropriate use criteria could be used for other services under this part, such as radiation therapy and clinical diagnostic laboratory services.".

SEC. 7. EMPOWERING BENEFICIARY CHOICES THROUGH ACCESS TO INFORMATION ON PHYSICIANS' SERVICES.

(a) TRANSFERRING FREESTANDING PHYSICIAN COMPARE PROVISION TO THE SOCIAL SECURITY ACT.—

(1) IN GENERAL.—Section 10331 of Public Law 111–148 is transferred and redesignated as subsection (t) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (h) of section 2 and by section 3.

(2) CONFORMING REDESIGNATIONS.—Section 1848(t) of the Social Security Act (42 U.S.C. 1395w–4(t)), as transferred and redesignated by paragraph (1), is further amended—

(A) by striking the subsection heading and inserting the following new subsection heading: "PUBLIC REPORTING OF PERFORMANCE AND OTHER INFORMATION ON PHYSICIAN COMPARE.—";

(B) by redesignating subsections (a) through (i) as paragraphs (1) through (9), respectively, and indenting appropriately;

(C) in paragraph (1), as redesignated by subparagraph (B)—

(i) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting appropriately;

(ii) in subparagraph (B), as redesignated by clause (i), by redesignating subparagraphs (A) through (G) as clauses (i) through (vii), respectively, and indenting appropriately;

(D) in paragraph (2), as redesignated by subparagraph (B), by redesignating paragraphs (1) through (7) as subparagraphs (A) through (G), respectively, and indenting appropriately; and

(E) in paragraph (9), as redesignated by subparagraph (B), by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively, and indenting appropriately.

(3) CONFORMING AMENDMENTS.—Section 1848(t) of the Social Security Act (42 U.S.C. 1395w–4(t)), as amended by paragraph (2), is further amended—

(A) in paragraph (1)—

(i) in subparagraph (A)—

(I) by striking "the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j))" and inserting "the program under this title under section 1866(j)"; and

(II) by striking "of such Act (42 U.S.C. 1395w–4)"; and

(ii) in subparagraph (B), in the matter preceding clause (i)—

(I) by striking "subsection (c)" and inserting "paragraph (3)";

(II) by striking "the Medicare program under such section 1866(j)" and inserting "the program under this title under section 1866(j)"; and

(III) by striking "this section" and inserting "this subsection";

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking "subsection (a)(2)" and inserting "paragraph (1)(B)";

(ii) in subparagraph (D), by striking "the Medicare program" and inserting "the program under this title"; and

(iii) in each of subparagraphs (F) and (G), by striking "this section" and inserting "this subsection";

(C) in paragraph (3), by striking "this section" and inserting "this subsection";

(D) in paragraph (4)—

(i) by striking "of the Social Security Act, as added by section 3014 of this Act"; and

(ii) by striking "this section" and inserting "this subsection";

(E) in paragraph (5)—

(i) by striking "this subsection (a)(2)" and inserting "paragraph (1)(B)"; and

(ii) by striking "(Public Law 110–275)";

(F) in paragraph (6), by striking "subsection (a)(1)" and inserting "paragraph (1)(A)";

(G) in paragraph (7)—

(i) by striking "subsection (f)" and inserting "paragraph (6)"; and

(ii) by striking "title XVIII of the Social Security Act" and inserting "this title";

(H) in paragraph (8)—

(i) by striking "subparagraphs (A) through (G) of subsection (a)(2)" and inserting "clauses (i) through (vii) of paragraph (1)(B)";

(ii) by striking "title XVIII of the Social Security Act" and inserting "this title"; and

(iii) by striking "such title" and inserting "this title"; and

(I) in paragraph (9)—

(i) in the matter preceding subparagraph (A), by striking "this section" and inserting "this subsection";

(ii) in subparagraph (A), by striking "of the Social Security Act (42 U.S.C. 1395w–4)";

(iii) in subparagraph (B), by striking "of such Act (42 U.S.C. 1395x(r))";

(iv) in subparagraph (C), by striking "subsection (a)(1)" and inserting "paragraph (1)(A)"; and

(v) by striking subparagraph (D).

(b) PUBLIC AVAILABILITY OF MEDICARE DATA.—Section 1848(t) of the Social Security Act (42 U.S.C. 1395w–4(t)), as amended by subsection (a), is further amended—

(1) by redesignating paragraph (9) as paragraph (10);

(2) by inserting after paragraph (8) the following new paragraph:

"(9) PUBLIC AVAILABILITY OF ELIGIBLE PROFESSIONAL CLAIMS DATA.—

"(A) IN GENERAL.—The Secretary shall make publicly available on Physician Compare the information described in subparagraph (B) with respect to eligible professionals.

"(B) INFORMATION DESCRIBED.—The following information, with respect to an eligible professional, is described in this subparagraph:

"(i) Information on the number of services furnished by the eligible professional, which may include information on the most frequent services furnished or groupings of services.

"(ii) Information on submitted charges and payments for services under this part.

"(iii) A unique identifier for the eligible professional that is available to the public, such as a national provider identifier.

"(C) SEARCHABILITY.—The information made available under this paragraph shall be searchable by at least the following:

"(i) The specialty or type of the eligible professional.

"(ii) Characteristics of the services furnished, such as volume or groupings of services.

"(iii) The location of the eligible professional.

"(D) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

"(E) IMPLEMENTATION.—

"(i) INITIAL IMPLEMENTATION.—Physician Compare shall include the information described in subparagraph (B)—

"(I) with respect to physicians, by not later than July 1, 2015; and

"(II) with respect to other eligible professionals, by not later than July 1, 2016.

"(ii) ANNUAL UPDATING.—The information made available under this paragraph shall be updated on Physician Compare not less frequently than on an annual basis.

"(F) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for an eligible professional to review, and submit corrections for, the information to be made public with respect to the eligible professional under this paragraph prior to such information being made public."; and

(3) in paragraph (10)(C), as redesignated by paragraph (1), by inserting "(or a successor website)" before the period at the end.

SEC. 8. EXPANDING CLAIMS DATA AVAILABILITY TO IMPROVE CARE.

(a) EXPANSION OF USES OF CLAIMS DATA BY QUALIFIED ENTITIES.—Section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) is amended by adding at the end the following new paragraph:

"(5) EXPANSION OF USES OF CLAIMS DATA BY QUALIFIED ENTITIES.—

"(A) EXPANSION.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2014, notwithstanding paragraph (4)(B) (other than clause (iii) of such paragraph) and the second sentence of paragraph (4)(D), a qualified entity may, as determined appropriate by the Secretary, do any or all of the following:

"(i)(I) Use the combined data described in paragraph (4)(B)(iii) to conduct analyses, other than for reports described in paragraph (4), for entities described in subparagraph (B) for non-public uses, as determined appropriate by the Secretary, such as for the purposes described in subclause (II).

"(II) The purposes described in this subclause are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities (including developing new models of care), population health management, and disease monitoring, and the purposes described in subparagraph (C).

"(ii) Provide or sell such analyses to entities described in subparagraph (B).

"(iii) Provide entities described in clauses (i), (ii), (v), and (vi) of subparagraph (B) with access to the combined data described in paragraph (4)(B)(iii) through a qualified data enclave (as defined in subparagraph (F)) that is maintained by the qualified entity in order for entities described in such clauses to conduct analyses for non-public uses, such as for the purposes described in clause (i)(II).

"(B) ENTITIES DESCRIBED.—For the purpose of subparagraph (A) clauses (i) and (ii), the entities described in this subparagraph are the following:

"(i) A provider of services.

"(ii) A supplier.

"(iii) Subject to subparagraph (C), an employer (as defined in section 3(5) of the Employee Retirement Insurance Security Act of 1974).

"(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act) that provides data under paragraph (4)(B)(iii).

"(v) A medical society or hospital association.

"(vi) Other entities approved by the Secretary (other than an employer (as so defined) and a health insurance issuer (as so defined)).

"(C) LIMITATION WITH RESPECT TO EMPLOYERS.—Any analyses provided or sold under this paragraph to an employer (as so defined) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

"(D) PROTECTION OF PATIENT IDENTIFICATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), an analysis provided or sold under this paragraph shall not contain information that individually identifies a patient.

"(ii) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—An analysis that is provided or sold under this paragraph to a provider of services or supplier may contain data that individually identifies a patient of such provider or supplier but only with respect to items and services furnished by such provider or supplier to such patient.

"(iii) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis under this paragraph to an entity described in subparagraph (B), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide an opportunity for such provider or supplier to review and submit corrections to such analysis.

"(E) NO REDISCLOSURE.—An entity described in subparagraph (B) that is provided or sold an analysis under this paragraph shall not redisclose or make public such an analysis.

"(F) REQUIREMENTS FOR A QUALIFIED DATA ENCLAVE.—

"(i) DEFINITION.—For purposes of this paragraph, the term 'qualified data enclave' means a data enclave that the Secretary determines meets the following:

"(I) The data enclave is a web-based portal or comparable mechanism.

"(II) Subject to the requirements described in clause (ii) and such other requirements as the Secretary may specify, the data enclave is capable of providing access to the combined data described in subparagraph (A)(iii).

"(ii) ENCLAVE ACCESS REQUIREMENTS.—The requirements described in this clause are the following:

"(I) A qualified data enclave shall preclude any entity that obtains access to the data from removing or extracting the data from such enclave.

"(II) Subject to the succeeding sentence, the enclave shall preclude access to data that individually identifies a patient, including data on the patient's name and date of birth and such other data as the Secretary shall specify. Such data enclave may provide providers of services and suppliers with access to such individually identifiable patient data but only with respect to items and services furnished by such provider or supplier to such patient.

"(III) Access to data in the enclave shall not be provided to any entity unless the qualified entity and the entity have entered into a data use agreement, the terms of which contain the requirements of this paragraph and such other terms the Secretary may specify.

"(G) ANNUAL REPORTS.—Any qualified entity that provides or sells analyses pursuant to subparagraph (A)(ii) or provides access to a qualified data

enclave pursuant to subparagraph (A)(iii) shall annually submit to the Secretary a report that includes—

"(i) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses;

"(ii) a description of the topics and purposes of such analyses;

"(iii) information on the entities who obtained access to the qualified data enclave, the uses of the data, and the total amount of fees received for providing such access; and

"(iv) other information determined appropriate by the Secretary.".

(b) EXPANSION OF DATA AVAILABLE TO QUALIFIED ENTITIES.—Section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) is amended—

(1) in the subsection heading, by striking "Medicare"; and

(2) in paragraph (3)—

(A) by inserting after the first sentence the following new sentence: "Effective July 1, 2014, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity."; and

(B) in the last sentence, by inserting "or under titles XIX or XXI" before the period at the end.

(c) ACCESS TO MEDICARE DATA BY QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—Section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)) is amended by adding at the end the following new clause:

"(vi) ACCESS TO MEDICARE DATA TO FACILITATE QUALITY IMPROVEMENT.—

"(I) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, and subject to other requirements as the Secretary may specify, beginning July 1, 2014, the Secretary shall, if requested by a qualified clinical data registry under this subparagraph, subject to subclauses (II) and (III), provide data as described in section 1874(e)(3) (in a form and manner determined to be appropriate) to such registry for purposes of linking such data with clinical data and performing analyses and research to support quality improvement or patient safety.

"(II) PROTECTION.—A qualified clinical data registry may not publicly report any data made available under subclause (I) (or any analyses or research described in such subclause) that individually identifies a provider of services, supplier, or individual unless the registry obtains the consent of such provider, supplier, or individual prior to such reporting.

"(III) FEE.—The data described in subclause (I) shall be made available to qualified clinical data registries at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited in the Centers for Medicare & Medicaid Services Program Management Account.".

(d) REVISION OF PLACEMENT OF FEES.—Section 1874(e)(4)(A) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(A)) is amended, in the second sentence—

(1) by inserting ", for periods prior to July 1, 2014," after "deposited"; and

(2) by inserting the following before the period at the end: ", and, beginning July 1, 2014, into the Centers for Medicare & Medicaid Services Program Management Account".

SEC. 9. REDUCING ADMINISTRATIVE BURDEN AND OTHER PROVISIONS.

(a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-OUT TO PRIVATE CONTRACT.—

(1) INDEFINITE, CONTINUING AUTOMATIC EXTENSION OF OPT OUT ELECTION.—

(A) IN GENERAL.—Section 1802(b)(3) of the Social Security Act (42 U.S.C. 1395a(b)(3)) is amended—

(i) in subparagraph (B)(ii), by striking "during the 2-year period beginning on the date the affidavit is signed" and inserting "during the applicable 2-year period (as defined in subparagraph (D))";

(ii) in subparagraph (C), by striking "during the 2-year period described in subparagraph (B)(ii)" and inserting "during the applicable 2-year period"; and

(iii) by adding at the end the following new subparagraph:

"(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, the term 'applicable 2-year period' means, with respect to

an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.".

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply to affidavits entered into on or after the date that is 60 days after the date of the enactment of this Act.

(2) PUBLIC AVAILABILITY OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section 1802(b) of the Social Security Act (42 U.S.C. 1395a(b)) is amended—

(A) in paragraph (5), by adding at the end the following new subparagraph:

"(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—The term 'opt-out physician or practitioner' means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).";

(B) by redesignating paragraph (5) as paragraph (6); and

(C) by inserting after paragraph (4) the following new paragraph:

"(5) POSTING OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—

"(A) IN GENERAL.—Beginning not later than February 1, 2015, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

"(B) INFORMATION TO BE INCLUDED.—The information to be made available under subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

"(i) Their number.

"(ii) Their physician or professional specialty or other designation.

"(iii) Their geographic distribution.

"(iv) The timing of their becoming opt-out physicians and practitioners, relative to when they first entered practice and with respect to applicable 2-year periods.

"(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.".

(b) MEDICARE NON-PARTICIPATING PHYSICIANS DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish and implement a demonstration project (in this section referred to as the "demonstration project") under title XVIII of the Social Security Act to provide that payments for services under such title furnished by non-participating physicians (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1))) to individuals entitled to benefits under part A or enrolled under part B of such title are paid directly to such physicians. The Secretary shall carry out the demonstration project in a geographic area that is a statistically significant area no larger than a State.

(2) ADVANCE NOTICE TO PHYSICIANS.—The Secretary shall, in a timely manner and prior to the beginning of the year in which payment will be made under the demonstration project, notify physicians in the geographic area described in paragraph (1) of the option to participate in the demonstration project.

(3) TIMETABLE FOR IMPLEMENTATION.—

(A) DEMONSTRATION START DATE.—The demonstration project shall apply with respect to services furnished beginning on January 1, 2015.

(B) 1-YEAR DURATION.—The Secretary shall implement the demonstration project such that payments are made under such demonstration project for a period of 1 year.

(4) REPORT.—Not later than 18 months after the date of the conclusion of the demonstration project, the Secretary shall submit to Congress a report analyzing the impact of the demonstration project. Such report shall include an analysis of the impact, if any, of the demonstration project upon the—

(A) percentage and number of physicians who choose not to participate under title XVIII of the Social Security Act and a comparison of such percentage and number to the previous year;

(B) percentage of claims submitted by and payments made to physicians in the demonstration that are unassigned and a comparison of unassigned claims and payments by non-participating physicians in the previous year;

(C) percentage and number of the physicians in the demonstration by specialty designation; and

(D) access to services for which payment is made under such title for individuals entitled to benefits under part A or enrolled under part B of such title.

(5) BENEFICIARY NOTICE.—

(A) NOTICE BY SECRETARY TO BENEFICIARIES.—The Secretary shall notify individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act in the geographic area in which the demonstration project is conducted of the implications of physician participation in the demonstration project.

(B) NOTICE BY PHYSICIANS TO PATIENTS.—A physician who elects to participate in the demonstration project shall notify individuals to whom the physician furnishes services for which payment will be provided under the demonstration project of such election. Such notification shall be provided prior to the provision of service and include a notification, with respect to each such individual, that—

(i) the right of the individual to payment is being reassigned to the physician;

(ii) payment for services furnished by the physician to such individual will be made directly to the physician; and

(iii) the individual is responsible for the remaining amount, which may be higher than would be the case if the physician participated in the Medicare program.

(c) GAINSHARING STUDY AND REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall submit to Congress a report with legislative recommendations to amend existing fraud and abuse laws, through exceptions, safe harbors, or other narrowly targeted provisions, to permit gainsharing or similar arrangements between physicians and hospitals that improve care while reducing waste and increasing efficiency. The report shall—

(1) consider whether such provisions should apply to ownership interests, compensation arrangements, or other relationships; and

(2) describe how the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care; and

(3) consider whether a portion of any savings generated by such arrangements should accrue to the Medicare program under title XVIII of the Social Security Act.

(d) PROMOTING INTEROPERABILITY OF ELECTRONIC HEALTH RECORD SYSTEMS.—

(1) RECOMMENDATIONS FOR ACHIEVING WIDESPREAD EHR INTEROPERABILITY.—

(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare EHR incentive programs, Congress declares it a national objective to achieve widespread and nationwide exchange of health information through interoperable certified EHR technology by December 31, 2019.

(B) DEFINITIONS.—In this paragraph:

(i) WIDESPREAD INTEROPERABILITY.—The term "widespread interoperability" means nationwide interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare EHR incentive programs and other clinicians and health care providers.

(ii) INTEROPERABILITY.—The term "interoperability" means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

(C) ESTABLISHMENT OF METRICS.—Not later than December 31, 2015, and in consultation with stakeholders, the Secretary shall establish metrics to be used to determine if and to the extent that the objective described in subparagraph (A) has been achieved.

(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services determines that the objective described in subparagraph (A) has not been achieved by December 31, 2017, then the Secretary shall submit to Congress a report, by not later than December 31, 2018, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

(i) to adjust payments for meaningful EHR users under the Medicare EHR incentive programs; and

(ii) for criteria for decertifying certified EHR technology products.

(2) PREVENTING BLOCKING THE SHARING OF INFORMATION.—

(A) FOR MEANINGFUL EHR PROFESSIONALS.—Section 1848(o)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(ii)) is amended by inserting before the period at the end the following: ", and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation similar to that required in the health information technology donation safe harbor established under regulations under section 1128B(b)(3)(E)) that the professional has not and will not take any deliberate action to limit or restrict the use, compatibility, or interoperability of the certified EHR technology".

(B) FOR MEANINGFUL EHR HOSPITALS.—Section 1886(n)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amended by inserting before the period at the end the following: ", and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation referred to in section 1848(o)(2)(A)(ii)) that the hospital has not and will not take any deliberate action to limit or restrict the use, compatibility, or interoperability of the certified EHR technology".

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to meaningful EHR users as of the date that is 6 months after the date of the enactment of this Act.

(3) STUDY AND REPORT ON THE FEASIBILITY OF ESTABLISHING A WEBSITE TO COMPARE CERTIFIED EHR TECHNOLOGY PRODUCTS.—

(A) STUDY.—The Secretary shall conduct a study to examine the feasibility of establishing a website (in this subsection referred to as the "website") that includes aggregated results of surveys of meaningful EHR users on the functionality of certified EHR technology products to enable such users to directly compare the functionality and other features of such products. Such information may be made available through contracts with physician, hospital, or other organizations that maintain such comparative information.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the website. The report shall include information on the benefits and resources of such a website.

(4) DEFINITIONS.—In this subsection:

(A) The term "certified EHR technology" has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4)).

(B) The term "meaningful EHR hospital" means an eligible hospital (as defined in section 1886(n)(6)(A) of the Social Security Act (42 U.S.C. 1395ww(n)(6)(A)) that is a meaningful EHR user.

(C) The term "meaningful EHR professional" means an eligible professional (as defined in section 1848(o)(5)(C) of the Social Security Act (42 U.S.C. 1395w–4(o)(5)(C)) who is a meaningful EHR user.

(D) The term "meaningful EHR user" has the meaning given such term under the Medicare EHR incentive programs.

(E) The term "Medicare EHR incentive programs" means the incentive programs under section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395w–4(o), 1395w–23, 1395ww(n)).

(F) The term "Secretary" means the Secretary of Health and Human Services.

(e) GAO STUDY AND REPORT ON THE USE OF TELEHEALTH UNDER FEDERAL PROGRAMS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the following:

(A) How the definition of telehealth across various Federal programs and federal efforts can inform the use of telehealth in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) Issues that can facilitate or inhibit the use of telehealth under the Medicare program under such title, including oversight and professional licensure, changing technology, privacy and security, infrastructure requirements, and varying needs across urban and rural areas.

(C) Potential implications of greater use of telehealth with respect to payment and delivery system transformations under the Medicare program

under such title XVIII and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(D) How the Centers for Medicare & Medicaid Services conducts oversight of payments made under the Medicare program under such title XVIII to providers for telehealth services.

(2) REPORT.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(f) RULE OF CONSTRUCTION REGARDING HEALTH CARE PROVIDER STANDARDS OF CARE.—

(1) IN GENERAL.—The development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

(2) DEFINITIONS.—For purposes of this subsection:

(A) The term "Federal health care provision" means any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I and subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), and titles XVIII and XIX of the Social Security Act.

(B) The term "health care provider" means any individual or entity—

(i) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

(ii) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(C) The term "medical malpractice or medical liability action or claim" means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider's prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act).

(D) The term "State" includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) NO PREEMPTION.—No provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013, as reported, repeals the Sustainable Growth Rate (SGR) mechanism and reforms how Medicare pays for services furnished by physicians and other practitioners, referred to as "professionals."

The bill repeals the applicability of the SGR to provide needed long-term stability to payments to professionals. It establishes an annual payment update of 0.5 percent for the years 2014, 2015 and 2016. After this three-year period during which no other changes are made to the current payment system, the bill establishes a single professional payment incentive program that represents consolidation and improvement of the three incentive programs that existing under current law. This single incentive program, referred to as the Value-Based Performance Incentive Program (VBP), continues the focus on quality, resource use, and electronic health record (EHR) use with which professionals are familiar, but in a cohesive program that avoids redundancies. The bill provides incen-

tives for professionals to participate in alternative payment models (APMs).

The bill also: improves the coordination of care furnished to beneficiaries; improves the accuracy of payment rates; provides information to providers and beneficiaries to facilitate high-quality, efficient care; and ensures that payments by federal programs for the provision of care could not be used to establish a standard of care in medical liability cases.

B. Background and Need for Legislation

In the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress established the Resource-Based Relative Value Scale (RBRVS) as the system for paying professionals for the services they provide to Medicare beneficiaries. The RBRVS system bases payments on the amount of resources, or inputs, involved in providing each individual service. The schedule of payments, or fees, set for each service replaced the previous method of paying based on the lesser of what was considered to be the "customary, prevailing, or reasonable" charge for a service. OBRA of 1989 also established a system that created an aggregate annual target for spending under the RBRVS, known as Medicare Volume Performance Standards (MVPS). The MVPS system included no significant penalty for professionals if the target was exceeded. The RBRVS and the MVPS were implemented in 1992. However, Congress established the SGR mechanism in the Balanced Budget Act of 1997 (BBA) to replace MVPS as a mechanism for constraining physician fee schedule spending because expenditures consistently exceeded MVPS targets.

The SGR mechanism determines updates to the physician fee schedule by establishing an annual growth allowance that is tied to the rate of growth in the overall economy. The SGR is cumulative, meaning that an ongoing tally of actual and target expenditures has been maintained since the formula's inception. If actual expenditures are lower than the cumulative target in a year, payments for professionals' services are increased in the following year. If actual expenditures are higher than the cumulative target, payments for services are decreased. While the SGR addresses payment for individual services, there is no limit on the volume or intensity of services provided.

Actual physician fee schedule spending came in under the target from 1997 through 2000, resulting in significant payment increases during those years; however, since 2001, spending has consistently exceeded the target. Accordingly, the SGR mechanism has called for a reduction in physician fee schedule service payments in each year since 2002. Congress has intervened to avert the cut each year since 2003 through numerous pieces of legislation. Starting in 2006, the legislative efforts to override the SGR's cuts were fashioned to reduce the cost at the time of action, but result in deeper subsequent cuts. As a result of such legislation and the cumulative nature of the SGR, the current projected payment reduction to professionals' services is significant. With the most recent Congressional intervention, through the Bipartisan Budget Act of 2013 (P.L. 113–67), the effects of the SGR have been delayed until March 31, 2014. Without further action, there will be an across-

the-board reduction in payments of nearly 24 percent beginning on April 1, 2014.

The Committee believes that the SGR is flawed and needs to be repealed. The SGR is a blunt payment mechanism based on macroeconomic indicators and has shown little ability to influence care decisions made by individual professionals. Further, it results in a payment increase or decrease that applies equally to all services and professionals regardless of their individual practice patterns. The looming threat of an SGR payment reduction is disruptive to professionals and threatens beneficiary access to care. Congress has spent a total of more than $150 billion enacting numerous laws to avert pending SGR cuts without addressing the underlying problems of the SGR. This spending has historically been offset by policy changes that reduce spending elsewhere in the Medicare program. The perpetual need to address pending SGR cuts occupies an inordinate amount of Congress' time and attention, which detracts from other priorities. The Committee believes now is the time to address the underlying problem by eliminating the SGR and enacting critical payment system reforms that promote more accountable, value-driven care.

C. Legislative History

BACKGROUND

The Chairman's Amendment in the Nature of a Substitute (AINS) to H.R. 2810, the "Medicare Patient Access and Quality Improvement Act of 2013," was made publicly available through the Committee's website on December 11, 2013.

COMMITTEE ACTION

The Committee marked up H.R. 2810 on December 12, 2013 and ordered the bill favorably reported to the House of Representatives as amended by a rollcall vote of 39 yeas and 0 nays (with a quorum being present).

COMMITTEE HEARINGS

On July 24, 2012, the Subcommittee on Health had a hearing on physician organization efforts to enhance the value of care delivered to patients. The Subcommittee heard testimony from:

- Dr. Lawrence Riddles, President, American College of Physician Executives;
- Dr. David Bronson, President, American College of Physicians;
- Dr. Michael Weinstein, American Gastroenterological Association;
- Dr. Peter Mandrell, American Academy of Orthopaedic Surgeons;
- Aric Sharp, CEO, Quincy Medical Group, Quincy, IL; and
- Dr. John Jenrette, CEO, Sharp Community Medical Group, San Diego, CA.

On February 7, 2012, the Subcommittee on Health had a hearing on private payers efforts to reward professionals who deliver high-quality and efficient care. The Subcommittee heard testimony from:

- Lewis G. Sandy, MD, Senior Vice President, Clinical Advancement, UnitedHealth Group;

- David Share, MD, MPH, Vice President, Value Partnerships, Blue Cross Blue Shield Michigan;
- Jack Lewin, MD, Chief Executive Officer, American College of Cardiology;
- John L. Bender, MD, President and CEO, Miramont Family Medicine, Ft. Collins, Colorado; and
- Len M. Nichols, PhD, Professor of Health Policy, Director of Center for Health Policy Research and Ethics, George Mason University.

On February 12, 2011, the Subcommittee on Health had a hearing on innovative models that provide an alternative to fee-for-service payments. The Subcommittee heard testimony from:

- Stuart Guterman, MA, Vice President, Payment and System Reform/Executive Director, Commission on a High Performance Health System, The Commonwealth Fund;
- Lisa Dulsky Watkins, MD, Associate Director, Vermont Blueprint for Health, Department of Vermont Health Access;
- Dana Gelb Safran, ScD, Senior Vice President for Performance Measurement and Improvement, Blue Cross Blue Shield of Massachusetts; and
- Keith Wilson, MD, Chair, Governing Board and Executive Committee, California Association of Physician Groups.

II. EXPLANATION OF THE BILL

Section 1. Short title

The short title of the bill is the "SGR Repeal and Medicare Beneficiary Access Act of 2013."

Section 2. Repealing the Sustainable Growth Rate (SGR) and improving Medicare payment for physicians' services

PRESENT LAW

In the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress established the Resource-Based Relative Value Scale (RBRVS) as the system for paying professionals for the services they provide to Medicare beneficiaries. The RBRVS system bases payments on the amount of resources (inputs) involved in providing each service. The schedule of payments, or fees, set for each service replaced the previous method of paying based on the lesser of what was considered to be the "customary, prevailing, or reasonable" charge for a service.

Under the RBRVS, the Secretary assigns relative value units (RVUs) to each of the approximately 7,500 service codes that reflect the amount of work, practice expenses and professional liability costs. RVU assignments are meant to reflect the relative difference in the resources between the various services. The assigned RVUs are then adjusted for geographic variation in resource costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

OBRA of 1989 also established a system that created an annual target for spending under the RBRVS, known as Medicare Volume Performance Standards (MVPS). The MVPS system established an aggregate annual spending target, though there was no significant consequence if it was exceeded. The RBRVS and the MVPS were

implemented in 1992. Congress established the SGR mechanism in the Balanced Budget Act of 1997 (BBA) as a more forceful mechanism for constraining physician fee schedule spending after expenditures consistently exceeded MVPS targets.

The SGR mechanism established an annual growth allowance that tied the rate of growth in payments for professionals' services to growth in the overall economy. The SGR is cumulative, meaning that an ongoing tally of actual and target expenditures has been maintained since the formula's inception. If actual expenditures are lower than the cumulative target in a year, payments for professionals' services are increased in the following year. If actual expenditures are higher than the cumulative target, payments are decreased. The BBA, however, did not cap total spending on professionals' services. Thus, even if payments for services were reduced, spending could increase if more services or more costly services were provided.

Given the state of the economy at the time, actual physician fee schedule spending came in under the target from 1997 through 2000, which resulted in significant payment increases during that period. However, spending has consistently exceeded the target in subsequent years. Accordingly, the SGR mechanism has called for a reduction in physician fee schedule service payments in each year since 2002. Congress has intervened to avert the cut each year since 2003 through numerous pieces of legislation. As a result of such legislation and the cumulative nature of the SGR, the projected payment reduction to professionals' services is significant. With the most recent Congressional intervention, through the Bipartisan Budget Act of 2013 (P.L. 113–67), the effects of the SGR have been delayed until March 31, 2014. However, without further action, the SGR mechanism will result in an across the board reduction in payments for professionals' services of nearly 24 percent beginning on April 1, 2014.

Over time, Congress has added incentive programs that adjust physician fee schedule payments with the intent to improve the quality of care delivered to Medicare beneficiaries and constrain the growth of spending for professional services. The three main incentive programs are described below.

The Physician Quality Reporting System (PQRS) adjusts payments based on whether professionals report on quality of care measures. Professionals receive bonus payments for successful reporting through 2014, with those who fail to successfully report receiving a downward payment adjustment starting in 2015.

The Value-Based Modifier (VBM) adjusts payment based on quality and resource use. Adjustments are made in a budget-neutral manner, meaning that increased payments to high performers are funded by payment reductions to low performers.

The EHR Meaningful Use program (EHR MU) adjusts payments based on whether a professional meets certain requirements in the use of a certified EHR system. Professionals receive a bonus payment through 2016, with those who fail to demonstrate meaningful use receiving a reduction starting in 2015.

In addition, there are various Medicare alternative payment models (APMs) available under current law, though professionals' ability to participate in them depends on a number of factors. Medicare pilots and demonstration projects, which are generally

mandated by Congress or established by the Secretary using administrative authority, are often conducted in a specific geographic area and have a limit on the number of participants. Congress established the Medicare Shared Savings Program (MSSP) that enables professionals and other providers to participate as Accountable Care Organizations (ACOs) that meet certain criteria on a nationwide basis.

COMMITTEE BILL

Stabilizing fee updates

This section permanently repeals the flawed SGR mechanism that updates payments, averting a 23.7 percent SGR-induced cut scheduled for January 1, 2014. Professionals receive an annual update of 0.5 percent in 2014–2016. The rates in 2016 are maintained through 2023. In 2023 and subsequent years, professionals participating in APMs that meet certain criteria receive annual updates of 2 percent, while all other professionals receive annual updates of 1 percent.

The Medicare Payment Advisory Commission (MedPAC) is required to submit reports to Congress in 2016 and 2020 that assesses the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D. The Committee recognizes the critical role of professionals in directing care and service use and believes it important to evaluate their impact on total program spending, including under the VBP program.

Consolidating current law programs into single incentive program

Payments to professionals are adjusted based on performance under a single, budget-neutral VBP starting in 2017. The VBP streamlines and improves upon the three distinct current law incentive programs mentioned above. The payment implications associated with the current law incentive program penalties are sunset at the end of 2016. The penalties that would have been assessed under those programs remain in the payment system.

Professionals to whom VBP applies

The VBP applies to: physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in 2017. It could apply to all others professionals paid under the physician fee schedule beginning in 2019. While the Secretary has discretion to decide whether to expand to these other professionals, the Committee intends that all professionals with metrics that enable a fair assessment of performance be included in the VBP. Professionals who treat few Medicare beneficiaries are excluded from the VBP. The Committee intends that this low beneficiary volume threshold be set so as to exclude professionals whose performance cannot be reliably assessed.

VBP assessment categories

The VBP assesses the performance of eligible professionals in four categories: quality; resource use; EHR Meaningful Use; and clinical practice improvement activities.

Quality measures used in PQRS are to be used for the quality category. However, the Secretary is required to solicit recommended measures annually and fund both professional organizations and others to develop additional measures for consideration. Measures used in qualified clinical data registries can be used to assess performance. The Committee believes that these steps promote the development and use of measures that are meaningful to beneficiaries.

Metrics used in the current VBM program are to be used for the resource use category. However, the methodology that the Secretary is currently developing to identify resources associated with specific episodes of care will be enhanced through public input and an alternative process that directly engages professionals. The alternative mechanism entails professionals reporting their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode) on the billing claim form. This supplemental mechanism addresses concerns that algorithms and attribution rules fail to accurately link the cost of services to a professional.

Further, the section requires additional research and recommendations on how to improve risk adjustment methodology to ensure that professionals are not penalized for serving sick or more costly patients. The Committee is concerned that providers who serve individuals with complex care needs or individuals from challenging socio-economic environments may have greater difficulty meeting some of the goals of value-based purchasing programs. The Secretary is required to complete two studies—one using existing Medicare data and another using other relevant risk factors—to examine the effects of patient-level variables on providers' performance under the VBP and similar Medicare programs. To the extent that these variables are found to have an effect, the results of these studies will be incorporated into the VBP, the Hierarchal Condition Category (HCC), and other Medicare value-based purchasing programs to ensure these programs accurately account for the characteristics associated with providers' specific patient populations. The Committee intends for the Secretary to use this information to continually improve the accuracy Medicare provider payments and to guard against potential selection issues that might compromise access to care for vulnerable populations.

The Committee believes the collection of race and ethnicity data is incomplete and that accurate data is necessary to better inform value-based purchasing programs. This section requires the Secretary to develop and report to Congress on a plan to collect and utilize this information within 18 months of enactment.

Resource use is to be first assessed in the VBP in 2020, a three-year delay from the 2017 start date that applies to the other categories. The Committee believes this delay provides more time for the development and improvement of methodologies, including more precise risk adjustment, that allow for more accurate resource use assessments and the associated payment incentives.

EHR Meaningful Use requirements, demonstrated by use of a certified system, continues to apply as the determinant of whether professionals receive credit in this category. To prevent duplicative reporting, professionals who report comparable quality measures

through certified EHR systems are deemed to meet the meaningful use clinical quality measure component.

Professionals will be assessed on their effort to engage in clinical practice improvement activities. The menu of recognized activities is to be established in collaboration with professionals. Activities must be applicable to all specialties and attainable for small practices and professionals in rural and underserved areas. The Committee believes that the inclusion of this category recognizes professionals who are currently performing such activities, prompts activities that can improve beneficiary care, and facilitates professionals' future participation in APMs.

Amount tied to performance and performance score determination

The funding available for VBP incentive payments is drawn from penalties assessed on low performers. In 2017, it is equal to 4 percent of the total estimated spending; in 2018, 6 percent; in 2019, 8 percent; and 10 percent in 2020. Starting 2021 or later, the funding pool could increase percent to 12 percent. The Committee believes that this phased-in approach, which reduces the amount of funding tied to incentive programs compared to current law in the initial VBP years, affords professionals more time to acclimate to the VBP program, as well as more time to develop meaningful quality and resource use metrics applicable to a broad range of professionals. It also ensures that VBP penalties remain and are redistributed within Medicare's fee schedule.

The entire funding pool for a year is required to be paid out in that year. Professionals' VBP payment reduction is to be no greater than the size of the funding percentage amount for the year (e.g., 4 percent in 2017); the maximum payment increase is to be no greater than funding percentage amount (e.g., 4 percent in 2017). While no professional is required to get the minimum or maximum, the Committee believes that these parameters provide certainty as to the potential payment adjustment range.

Professionals are to be assessed and receive payment adjustments based on a composite score determined by performance on the four categories. To incentivize upward movement, professionals also receive credit for improvement from one year to the next in the determination of their quality and resource use performance category scores.

As the Committee believes that professionals should be assessed on categories, measures, and activities relevant to their practice and important to the beneficiaries that they treat, this section directs the Secretary to assess performance on only those metrics that apply to a professional's practice. Further, the Secretary is directed to ensure that professionals who typically do not have face-to-face encounters with patients are assessed on meaningful metrics appropriate to their situation. The Committee intends that the Secretary will work with these professionals to establish appropriate metrics consistent with the intent of the categories, measures, and activities under the VBP.

The Government Accountability Office (GAO) is required to evaluate the VBP and issue reports in 2018 and 2021, including an assessment of the provider types, practice sizes, practice geography, and provider patient mix that are receiving VBP payment

increases and reductions. The Committee believes it is important to evaluate the impact of the VBP on an on-going basis, with these GAO reports contributing to that effort.

Expanded participation options and tools to enable success

The Committee believes it important to provide professionals with VBP participation options that enable engagement in the manner that best fits their practice situation. The Committee also believes it necessary to reduce the administrative burden associated with participation, as well as to provide information and assistance to promote success.

VBP participations options include: use of EHRs and clinical quality data registries maintained by physician specialty organizations; and the ability to be assessed as a group, as a "virtual" group, or with an affiliated hospital or other facility.

Professionals will receive confidential feedback on performance in the quality and resource use categories on an at least quarterly basis, likely through a web-based portal. This system of timely and actionable feedback replaces other, less effective mechanisms in current law. The portal allows professionals to report VBP information, as feasible and appropriate.

Technical assistance will be available through contracts with appropriate entities (such as Quality Improvement Organizations) to help practices with fewer than 20 professionals improve VBP performance or transition to APMs. Priority is to be given to practices with low VBP scores and those in rural and underserved areas. Funding is provided at $50 million annually from 2014 to 2018.

Encouraging participation in APMs

The Committee encourages participation in the testing of payment models that could serve as an alternative to the fee-for-service payment system and intends that APMs be available to interested professionals.

Professionals who receive a significant share of their revenues through an APM(s) that involves risk of financial losses and a quality measurement component receive a 5 percent bonus each year from 2017–2022. A patient-centered medical home APM is exempt from the downside financial risk requirement if proven to work in the Medicare population. Two tracks are available for professionals to qualify for the bonus. The first option is based on receiving a significant percent of Medicare revenue through an APM; the second is based on receiving a significant percent of APM revenue combined from Medicare and other payers. The second option makes it possible for professionals to qualify for the APM bonus even if Medicare APM options are limited in their area. Because APMs should be designed to contain specific accountability and measurement requirements, the Committee legislation stipulates that professionals who participate in APMs are excluded from the VBP assessment and most EHR meaningful use requirements.

To make the bonus opportunity available to the greatest number of professionals, the Secretary is specifically encouraged to test APMs relevant to specialty professionals and professionals in small practices, as well as those models that align with private and state-based payer initiatives.

While supportive of APM testing, the Committee highlights a few issues worthy of exploration. The Committee believes it prudent to examine the potential for fraud vulnerabilities associated with new models. Thus, this section directs the Secretary, in consultation with the Office of the Inspector General, to provide a report to Congress identifying program integrity vulnerabilities in new payment systems and, if found, provide recommendations with respect to needed legislative changes. Further, the Committee does not intend for APMs to compromise beneficiary access to needed care or innovative medical technologies or treatments. Scenarios that raise potential for concern include the time lapse that is common before the use of an approved innovation can be assessed through a well-vetted quality measure. Likewise, it is critical to design and monitor APMs for the possibility of stinting or other incentives that could diminish access to needed care. The Committee intends for the Secretary to work with stakeholders to ensure that APMs do not discourage needed care or innovation.

The Committee believes that APMs should be developed in consultation with professionals and other stakeholders and that public input can strengthen model development.

Section 3. Priorities and funding for quality measure development

PRESENT LAW

Measures for professionals are currently concentrated in certain specialties and services while other specialties and services have an insufficient number of measure. In addition, many current measures are process measures rather than more advanced measures, such as those for: outcomes; functional status; patient experience; care coordination; and appropriate use of services.

COMMITTEE BILL

This section addresses gaps in quality measurement programs to ensure meaningful measures on which to assess professionals and provides funding for measure development priorities.

The Secretary, with stakeholder input, is required to develop and publish a plan for the development of quality measures for use in the VBP and in APMs, by February 1, 2015. The plan is to take into account how measures from the private sector and integrated delivery systems can be utilized in the Medicare program. The plan is to prioritize outcome measures, patient experience measures, care coordination measures, and measures of appropriate use of services, and consider gaps in quality measurement and applicability of measures across health care settings.

By February 1, 2016, and annually thereafter, the Secretary is required to make public a report on the progress made in developing quality measures. The report is to include descriptions of the number of measures developed, including the name and type of each measure. The report will also include descriptions of measures under development, including an estimated timeline for completion of such measures, as well as quality areas being considered for future measure development. The Secretary is required to seek stakeholder input regarding gaps and prioritization of measure development in relation to the annual report.

This section makes available $15 million in annual funding in 2014 to 2018 for professional quality measure development. The Secretary is required to contract with entities, including physician organizations, to develop priority measures and encourage electronic specification of such measures. The funding remains available through fiscal year 2021. The Committee believes that organizations receiving such contracts should have measure development experience or otherwise demonstrate needed capability.

The Committee intends that the funding available for quality measure development facilitate the establishment and use of measures that are meaningful to beneficiaries and relevant to all professional types. The Committee believes that the funding helps offset the development costs of new measures that some physician organizations and other stakeholders view as a barrier to their development and use. The Committee intends that the Secretary work with stakeholders on an on-going basis to facilitate meaningful measures and coordination between developing entities.

Section 4. Encouraging care management for individuals with chronic care needs

PRESENT LAW

The most common physician fee schedule service is a visit to a professional's office for evaluation and management of a beneficiary's condition. Generally, the professional must have this type of face-to-face interaction with the beneficiary for Medicare to pay for a service. Beneficiaries with chronic care needs often require care management services, which typically involve a number of interventions that occur outside the face-to-face encounter. While payments for office visits are calculated to include some non-face-to-face care management, the amount is widely believed to be inadequate to properly coordinate the care of beneficiaries with complex care needs.

In the 2014 Medicare physician fee schedule final rule, CMS established a new payment for professionals for non-face-to-face chronic care management services that will begin January 1, 2015. The chronic care management payment will be in addition to the standard payment for a beneficiary visit to the professional's office. CMS intends to develop the requirements that a professional must meet to bill for these services through rulemaking for the 2015 physician fee schedule.

COMMITTEE BILL

This section establishes at least one payment code for use by professionals furnishing care management services to individuals with chronic conditions. Payment for such services is to be made to professionals practicing in a patient-centered medical home or comparable specialty practice certified by an organization(s) recognized by the Secretary beginning January 1, 2015. Only one professional or group practice can receive payment for these services provided to an individual during a specified period to prevent Medicare from making duplicative payments. Payment for this code(s) is budget-neutral within the physician fee schedule, and is not to be tied to an annual wellness or other preventive physical examination.

Section 5. Ensuring accurate valuation of services under the Physician Fee Schedule

PRESENT LAW

Medicare pays for more than 7,000 services under the physician fee schedule. Payment is equal to the sum of the relative value units (RVU)—adjusted for geographic differences in costs—for physician work, practice expense, and professional liability insurance for each service. A RVU reflects the relative resources (e.g., time, overhead, etc.) of one physician fee schedule service compared to another.

The Secretary is responsible for maintaining the physician fee schedule, which includes refining the methodology for establishing RVUs and modifying the RVUs assigned to each service. In establishing RVUs, the Secretary receives recommendations from the public, including the American Medical Association/Relative-Value Scale Update Committee (RUC). Modifications to RVUs for a service are done in a budget-neutral manner. Thus, payment increases from changes to the RVUs for some services must be offset by reductions in payment for all other services. The Secretary is required to review the RVUs no less than every five years.

Specifically, the Secretary is required to identify physician fee schedule services as being potentially misvalued on an on-going basis. To identify potentially misvalued services, the Secretary is to examine codes (and families of codes, as appropriate) that meet certain criteria, such as rapid growth in use.

COMMITTEE BILL

This section promotes greater accuracy in the values that are assigned to each individual service paid under the physician fee schedule.

Process to facilitate accurate valuation of services

The section permits the collection of information from professionals, other providers, and suppliers to assist in accurate valuation of services. Such information could include: practice expense inputs, time involved in furnishing services, cost and charge data, and other elements. The information could be collected via such mechanisms as surveys, practice logs, facility records, and electronic health records. This section makes funding available to compensate professionals who submit the requested information starting in 2014.

It expands the list of criteria the Secretary can use to identify services that may be misvalued to include codes: that account for a majority of spending; with substantial changes in procedure time; for which there may be a change in the site of service or a significant difference in payment between sites of service; services that may have greater efficiencies when performed together; or with high practice expenses or high cost supplies.

The Secretary is required to make any change to the valuation of a service through notice and comment rulemaking.

This section also sets an annual target for identifying misvalued services of 0.5 percent of the estimated amount of fee schedule expenditures in 2015, 2016, 2017, and 2018. If the target is met, that amount is redistributed in a budget-neutral manner within the

physician fee schedule. If the target is not met, fee schedule payments for the year are reduced by the difference between the target and the amount of misvalued services identified in a given year. If the target is exceeded, the amount in excess of the target is credited toward the following year's target.

The Committee does not intend to provide the Secretary new authority to establish or adjust service values by using service value or payment rates established under a system for paying other Medicare providers.

Other provisions

This section requires that downward adjustments to the total value of a service of 20 percent or more (as compared to the previous year) be phased-in over a two-year period. It provides the Secretary the authority to adjust service values to ensure that the difference between similar services is logical. The Committee expects only minor adjustments to be made to adjust for such differences.

The GAO is required to study the AMA/Specialty Society Relative Value Scale Update Committee (RUC) processes for making recommendations on the valuation of physician fee schedule services. The report is due no later than one year after enactment.

Adjustment to Medicare payment localities in California

This section improves the accuracy of physician fee schedule payments to professionals in California. Beginning in 2017, California payment areas transition from county-based localities, which have not been updated in 16 years, to Metropolitan Statistical Areas (MSAs), which are updated annually by the Office of Management and Budget (OMB) and factor into Medicare payments to hospitals. Areas not in an MSA are grouped together in a single "rest of state" payment area. MSAs better reflect the population movement that has occurred in California over that last decade and a half; under the present law county-based locality system San Diego and Sacramento are still classified as rural. Payments for areas that increase are phased-in over a six-year period. Areas that would experience a payment decrease under the new locality determinations are held harmless in that their payments cannot fall below the amount as it was adjusted under the county-based locality system.

Section 6. Promoting evidence-based care

PRESENT LAW

Medicare pays for outpatient imaging services through the physician fee schedule. Each imaging service is separated into two separate components: a "technical component," which encompasses the overhead required to furnish the service; and a "professional component," which represents the work involved in interpreting the results.

The Deficit Reduction Act of 2005 capped the technical component of the payment for services paid under the physician fee schedule at the level paid under the hospital outpatient prospective payment system effective January 1, 2007. Services subject to the cap are: X-rays, ultrasound (including echocardiography), nuclear

medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy.

The Secretary subsequently established and maintains policies that reduce payment for imaging services performed on noncontiguous body areas and the professional component for the second and subsequent services to the same patient, in the same session, on the same day.

The Secretary assumes a rate at which imaging machines are operated in calculating the payment amount for imaging services. Prior to 2011, the Secretary assumed that imaging machines were in use 50 percent of the time (25 hours per week) that practices are open for business. Congress required that the assumed use rate for imaging machines increase from 50 percent to 75 percent beginning January 1, 2011. Congress subsequently enacted legislation that will increase the assumed use rate to 90 percent beginning January 1, 2014.

COMMITTEE BILL

The Committee supports advanced diagnostic imaging services for beneficiaries who are in need of those services, but seeks to ensure that they receive the most appropriate service for their condition.

Selection of Appropriate Use Criteria (AUC)

This section requires the Secretary to establish a program that requires consultation with AUC for advanced imaging as a condition of Medicare payment. The Secretary is to specify one or more AUC(s) from among those developed or endorsed by national professional medical specialty societies or other entities by November 15, 2015. The Secretary is to take into account whether such criteria: have stakeholder consensus; are evidence-based; and are in the public domain. The Committee clarifies that the Secretary does not have the authority to develop AUC that can be used as a condition of payment for advanced imaging or any other Part B service.

Selection of qualified Clinical Decision Support (CDS) mechanisms

This section requires the Secretary to identify and publish a list of qualified CDS mechanisms, at least one of which must be free of charge, that could be used by ordering professionals to consult with applicable AUCs by April 1, 2016. Such mechanisms, which could be included in, or independent from, a certified EHR technology must: make available the applicable AUC(s) and supporting documentation; indicate the AUC(s) being used when more than one is available; determine the extent to which an imaging order follows the AUC(s); provide documentation to the ordering professional that such consultation occurred; be updated to reflect revisions to the AUC(s); and meet applicable privacy and security standards. The mechanism could be required to provide feedback to the ordering professional regarding that professional's aggregate adherence to applicable AUC(s).

Consultation with qualified CDS mechanisms

Beginning January 1, 2017, payment is only made to the furnishing professional for an advanced imaging service if the claim

for such service includes information: showing that the ordering professional consulted with a qualified CDS mechanism; as to whether the ordered service adheres to the applicable AUC(s); and listing the national provider identifier (NPI) of the ordering professional.

The requirement to consult with AUC(s) as a condition of payment does not apply to advanced imaging services: ordered for an individual with an emergency medical condition as defined under EMTALA; paid under Part A; ordered by professionals for individuals attributed to a APM that meets certain criteria; or ordered by professionals who meet hardship criteria, such as lack of Internet access.

Prior authorization

The Secretary is required to identify ordering professionals with low adherence to applicable AUC(s) ("outliers") based on two years of data. Beginning January 1, 2020, outliers shall be subject to prior authorization for specified advanced imaging services. This section provides $5 million in each of 2019, 2020, and 2021 for the Secretary to carry out the prior authorization program.

Potential application to other services

The GAO is required to provide a report to Congress no later than 18 months after enactment of the bill regarding other Part B services for which the use of clinical decision support mechanism is appropriate, such as radiation therapy and clinical diagnostic laboratory services.

The Secretary could establish an AUC program for other Part B services. The Secretary is required to consider the experience with the use of AUC(s) for advanced imaging services and the GAO report referenced above. The Secretary is required to obtain input from stakeholders through an Advanced Notice of Proposed Rulemaking prior to even proposing use of AUCs as condition for payment for another service for a specific year.

The Committee intends that the Secretary use the process established in statute for advanced imaging services if exercising the discretion to apply AUCs as a condition for payment for other Medicare Part B services. The Committee strongly believes it important that AUCs be developed or endorsed by physician specialty organizations or other organizations representing other providers as applicable. It clarifies that the Advanced Notice of Proposed Rulemaking is required to ensure thorough vetting prior to expansion to another service.

Section 7. Empowering beneficiary choices through access to information on physician services

PRESENT LAW

Congress required the Secretary to establish a Physician Compare website by January 1, 2011 that includes information on the physicians and other professionals who participate in the Physician Quality Reporting System (PQRS). The initial focus is on quality measures collected under PQRS. The Secretary is required to expand the information available to include information on efficiency, safety, patient health outcomes, and patient experience. The Sec-

retary is required to ensure that data made publicly available are statistically valid and reliable. The Secretary is required to report to Congress on the Compare website not later than January 1, 2015.

COMMITTEE BILL

The Committee believes it is important to make information on professionals' services publicly available to empower beneficiaries in making decisions about their health care.

Not later than July 1, 2015, for physicians and July 1, 2016, for other professionals, this section requires the Secretary to make utilization and payment data publicly available through the Medicare "Physician Compare" website. Such information is to include the number of services furnished, the charges submitted, and payments made for such services. The information is required to be searchable by the eligible professional name, provider type, specialty, location, and services furnished.

This section requires that the website indicate that the information may not be representative of the professional's entire patient population, variety of services furnished, or the health conditions of the individuals treated. Professionals must be given an opportunity to review and correct this information prior to its posting on the website.

The Committee expects that this information be presented in an easily understandable manner. The Committee believes that beneficiaries benefit most from information on the services (or group of similar services) that the professional furnishes most frequently.

Section 8. Expanding claims data availability to improve care

PRESENT LAW

Congress established a program that requires the Secretary to make claims data available to qualified entities (QEs) that can be used to measure health care provider performance. The Secretary provides QEs with standardized extracts of Medicare Parts A, B, and D claims data for one or more specified geographic areas and time periods. The fees for making data available are to be equal to the cost of providing the data. The Secretary must take action necessary to protect the identity of beneficiaries.

To be certified as a QE, entities must agree to: use claims data to evaluate the performance of providers on measures of quality, efficiency, effectiveness, and resource use; requirements governing the use of the data; and make performance reports on providers public.

When requesting Medicare data, a QE must submit to the Secretary a description of the methodologies that will be used to evaluate provider performance. They must also combine the Medicare data with claims data from another source.

A QE's public reports must include descriptive information on elements such as the quality measures and the professional attribution method used. Prior to their public release, any professional or other provider must be given an opportunity to appeal and correct errors.

Data released to a QE is not subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider.

COMMITTEE BILL

Qualified entities

Consistent with relevant privacy and security laws, entities that currently receive Medicare data for public reporting purposes (qualified entities, "QEs") are permitted to provide or sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them in their quality improvement activities. In order to ensure data security, the claims data are only to be accessible through a qualified data enclave (e.g., a web-based portal) from which the data could not be extracted. Any data or analyses must be de-identified, except for services furnished by the provider accessing the data enclave or receiving an analysis. QEs are permitted to provide or sell non-public analyses to health insurers and self-insured employers (only for purposes of providing health insurance to their employees or retirees). Providers identified in such analyses must be given an opportunity to review and submit corrections before the QE provides or sells the analysis to other entities.

QEs that provide or sell analyses or provide access to a data enclave are required to provide an annual report to the Secretary that includes an accounting of: the analyses provided or sold, including the number of analysis and purchasers, fees received, the topics and purposes; and access to the data enclave, including fees received, the entities that accessed the enclave, and how such data were used. Claims data available to QEs is expanded to include Medicaid and Children's Health Insurance Program data.

Qualified clinical data registries

Consistent with relevant privacy and security laws, the Secretary is required to make data available, for a fee that covers the cost of preparing the data, to qualified clinical data registries to support quality improvement and patient safety activities. Such registries must obtain consent prior to publicly reporting any data or analysis based on such data that is not de-identified.

Section 9. Reducing administrative burden and other provisions

PRESENT LAW

Physicians and some other professionals can "opt-out" of Medicare by informing the Secretary and providing certain information, including an affidavit. Professionals who opt out are generally prohibited from billing Medicare for services provided to any beneficiary for a two-year period. The professional has to inform the Secretary and provide the required information for each two-year opt-out period.

There is currently no requirement that the Secretary make public information on the number and characteristics of professionals who opt-out of Medicare.

Enrolled professionals identify annually whether they are Medicare "participating" or "non-participating." Participating professionals agree to accept the physician fee schedule amount, referred

to as the "allowed" amount, as the full payment for the service provided. Medicare makes its payment, typically 80 percent of the allowed amount, directly to the professional; the professional collects the remainder of the allowed amount from the beneficiary. Nonparticipating professionals can collect up to 115 percent of the Medicare allowed amount for a service. Medicare makes its payment, which is 75 percent of the allowed amount, to the beneficiary; the professional collects the full amount up to the 115 "limiting charge" from the beneficiary.

Under the EHR MU program, professionals must meet progressively rigorous requirements as established by the Secretary to demonstrate they are using an EHR in a meaningful way. The Secretary published the requirements for the second of three planned stages in 2012. These "Stage 2" rules require that a professional's EHR has exchanged information with at least one other EHR product. Stage 2 requirements do not emphasize interoperability between the wide variety of EHR products or widespread sharing of relevant information across provider settings and geographic areas.

COMMITTEE BILL

Rule of Construction regarding standard of care

This section provides that the development, recognition, or implementation of any guideline or other standard under any Federal health care provision, including Medicare, cannot be construed to establish the standard of care or duty of care owed by a health care professional to a patient in any medical malpractice or medical product liability action or claim.

Other provisions

This section: allows professionals who opt-out of Medicare to automatically renew at the end of each two-year cycle; requires regular reporting of opt-out professional characteristics; creates a demonstration project where Medicare pays a non-participating professional directly instead of paying a beneficiary for Medicare-approved services; requires that EHR programs be interoperable by 2019 and prohibits providers from deliberately blocking information sharing with other EHR vendor products; requires the Secretary to issue a report recommending how a permanent physician-hospital gainsharing program can best be established; and requires GAO to report on barriers to expanded use of telemedicine.

III. Votes of the Committee

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on its consideration of the AINS to H.R. 2810.

The bill, the "SGR Repeal and Medicare Beneficiary Access Act of 2013," was ordered favorably reported to the House of Representatives as amended by a rollcall vote of 39 yeas and 0 nays (with a quorum being present). The vote was as follows:

VOTES OF THE COMMITTEE

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Com-

mittee on Ways and Means during the markup consideration of H.R. 2810 "Medicare Patient Access and Quality Improvement Act of 2013."

The bill, H.R. 2810, was ordered favorably reported by a rollcall vote of 39 yeas to 0 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Camp	X			Mr. Levin	X		
Mr. Johnson	X			Mr. Rangel	X		
Mr. Brady	X			Mr. McDermott	X		
Mr. Ryan	X			Mr. Lewis	X		
Mr. Nunes	X			Mr. Neal	X		
Mr. Tiberi	X			Mr. Becerra	X		
Mr. Reichert	X			Mr. Doggett	X		
Mr. Boustany	X			Mr. Thompson	X		
Mr. Roskam	X			Mr. Larson	X		
Mr. Gerlach	X			Mr. Blumenauer	X		
Mr. Price	X			Mr. Kind	X		
Mr. Buchanan	X			Mr. Pascrell	X		
Mr. Smith	X			Mr. Crowley	X		
Mr. Schock	X			Ms. Schwartz	X		
Ms. Jenkins	X			Mr. Davis	X		
Mr. Paulsen	X			Ms. Sánchez	X		
Mr. Marchant	X						
Ms. Black	X						
Mr. Reed	X						
Mr. Young	X						
Mr. Kelly	X						
Mr. Griffin	X						
Mr. Renacci	X						

VOTES ON AMENDMENTS

No amendments to the bill were offered.

IV. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the revenue provisions of the bill as reported: The Committee agrees with the estimates prepared by the Congressional Budget Office (CBO), which is included below.

STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that the bill would result in increased expenditures of $121 billion over the 2014–2023 budget window.

B. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, January 24, 2014.

Hon. DAVE CAMP,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2810, the SGR Repeal and Medicare Beneficiary Access Act of 2013.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lori Housman.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

H.R. 2810—SGR Repeal and Medicare Beneficiary Access Act of 2013

Summary: H.R. 2810 would replace the Sustainable Growth Rate (SGR) formula, which determines the annual updates to payment rates for physician services in Medicare, with new systems for establishing those payment rates. CBO estimates that enacting H.R. 2810 would increase direct spending by about $121 billion over the 2014–2023 period. (The legislation would not affect federal revenues.) Pay-as-you-go procedures apply to this legislation because it would affect direct spending.

H.R. 2810 would impose an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) by preempting state laws governing the evidentiary rules and practices of medical malpractice claims. CBO estimates that the costs of the intergovernmental mandate would be small and would not exceed the threshold established in UMRA ($76 million in 2014, adjusted annually for inflation). The bill contains no private-sector mandates as defined in UMRA.

Estimated cost to the federal government: The estimated budgetary impact of H.R. 2810 is shown in the following table. The costs of this legislation fall within budget functions 570 (Medicare) and 550 (health).

	By fiscal year, in billions of dollars—											
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
CHANGES IN DIRECT SPENDING												
Estimated Budget Authority ..	5.3	10.6	10.9	11.1	10.7	12.0	13.5	14.9	16.5	15.5	48.7	121.1
Estimated Outlays	5.3	10.6	10.9	11.1	10.7	12.0	13.5	14.9	16.5	15.5	48.7	121.1

Note: Components may not sum to totals because of rounding.

Background and major provisions: Medicare compensates physicians for services they provide on the basis of a fee schedule that specifies payment rates for each type of covered service. Payment rates are based on a measure of the resources required to provide a given service (measured in relative value units or RVUs), adjusted to account for geographical differences in input prices, and translated into a dollar amount by applying a "conversion factor." The SGR formula determines the annual update to the conversion factor. Under current law, Medicare's payment rates for physicians'

services are slated to drop by about 24 percent in April 2014, and CBO projects those payment rates will increase by small amounts in most subsequent years but will remain below current levels throughout the next 10 years.

The Bipartisan Budget Act of 2013 (enacted as Public Law 113–67 in December of last year) made multiple changes to the Medicare program, including providing for a temporary increase of one-half percent in payment rates for services on the physician fee schedule furnished during January through March of 2014. As a result, conforming changes would have to be made to the version of H.R. 2810 that was approved by the Committee on Ways and Means earlier in December for its provisions to have the intended effects on Medicare payment rates. This estimate reflects the assumption that the legislation will include such conforming changes.

H.R. 2810 would replace the SGR with new payment systems over the next several years. The major provisions of the new payment systems specified in H.R. 2810 are as follows:

- The bill would increase Medicare's payment rates for services on the physician fee schedule by 0.5 percent for services furnished during calendar year 2015 and by another 0.5 percent for services furnished during 2016. (The Bipartisan Budget Act increased those payment rates by 0.5 percent for the first three months of calendar year 2014. This estimate assumes that conforming changes to H.R. 2810 would maintain payment rates at those levels for services on the physician fee schedule for the rest of calendar year 2014.)
- Payment rates for services on the physician fee schedule would remain at the 2016 level through 2023, but the amounts paid to individual providers would be subject to adjustment through one of two mechanisms, depending on whether the physician chooses to participate in a Value-Based Performance Incentive (VBP) program or an Alternative Payment Model (APM) program. (Both programs are described at greater length below.)

  Payments to providers who participate in the VBP program would be subject to positive or negative performance adjustments financed through a funding pool, with the positive and negative adjustments designed to be offsetting so that they have no net effect on overall payments. The performance adjustments could be as large as 4-percent of the amounts paid on the physician fee schedule for services provided by physicians participating in the VBP program in 2017, and that percentage would increase to between 10 percent and 12 percent in 2021 and subsequent years. The performance adjustment for an individual provider would depend on that provider's performance.
- Payments to providers who participate in an APM program (in particular, who receive a substantial portion of their revenue from alternative payment models) would receive, in 2017 through 2022, a lump-sum payment equal to 5 percent of their Medicare payments in the prior year for services paid on the physician fee schedule. Providers with revenue close to the APM revenue threshold would receive either no adjustment to their Medicare payments or the VBP performance adjustment if they reported measures and activities in that program. Providers would not be eligible for a lump-sum payment in 2023.

• For 2024 and subsequent years, there would be two payment rates for services paid on the physician fee schedule. For providers paid through the VBP program, payment rates would be increased each year by 1 percent. For providers paid through an APM, payment rates would be increased each year by 2 percent.

In addition, the bill would eliminate current-law penalties for providers who do not achieve meaningful use of electronic health records or satisfactorily report data on quality. However, physicians would have to meet standards for use of EHR and quality as part of the VBP program. Also, the bill would modify payment rates in certain California counties, adjust relative value units for certain physicians' services, and require the development of payment codes that would encourage care coordination and the use of medical homes.

Value-Based Performance Incentive Program

The legislation would establish a VBP that would measure the total performance of physicians and other medical providers based on information reported by those providers regarding quality measures, clinical practice improvement activities, resource use, and meaningful use of electronic health records. The Secretary of Health and Human Services would develop a methodology to assess total performance and determine a composite score. Beginning in 2017, providers with higher composite scores would receive positive performance adjustments and providers with lower composite scores would receive no or negative performance adjustments. The performance adjustments would not increase Medicare spending because reductions in payments made to providers with lower composite scores would be used to provide higher performance adjustments to providers with higher composite scores.

The Secretary would establish a funding pool to be used to distribute VBP payment adjustments by modifying the amount paid for each service based on the provider's composite score. The funding pool would rise from 4 percent of total payments under the physician fee schedule in 2017 to between 10 percent and 12-percent in 2021 and subsequent years.

Alternative Payment Model (APM) Program

From 2017 through 2022, certain providers who participate in eligible APMs would receive a lump-sum incentive payment equal to 5 percent of their aggregate payments from Medicare for the preceding year.

The legislation specifies the following types of Medicare-eligible APMs:

• Models that: (1) require the provider to bear financial risk, meet standards related to the use of electronic medical records, and meet quality measures comparable to the VBP program, and (2) are being tested through a demonstration program (or have been expanded after being tested) under Medicare or the Center for Medicare and Medicaid Innovation (CMMI); or

• A medical home program expanded after a successful demonstration conducted by CMMI that meets standards related to the use of electronic medical records and quality measures.

For 2017 and 2018, a provider would be eligible for the lump-sum payment of 5 percent if at least 25 percent of the provider's Medi-

care payments were for services furnished in an eligible APM. Providers who do not come within 5 percentage points of the Medicare share-of-revenue threshold would be subject to the rules of the VBP program. However, a provider who comes within 5 percentage points of meeting the threshold could choose between being paid the fee-schedule amount (without further adjustment) or being paid under the rules of the VBP program.

Beginning in 2019, the threshold for the share of revenue from eligible APMs necessary to be eligible for the lump-sum payment of 5 percent would rise, but the provider could count revenue from comparable non-Medicare APMs. Also beginning in that year, providers with revenue from an APM that is close to those thresholds would have a choice similar to that facing providers close to the thresholds in 2017 and 2018.

Basis of estimate: CBO estimates that enacting H.R. 2810 would increase direct spending by $48.7 billion over the 2014–2018 period and $121.1 billion over the 2014–2023 period, assuming enactment in the spring of 2014. Nearly all of the estimated increase in spending would stem from the specified updates to payment rates for services paid on the physician fee schedule. CBO estimates that maintaining current payment rates for the rest of 2014, providing 0.5 percent updates for 2015 and 2016, and then maintaining the 2016 level through 2023 would increase Medicare spending by $118.4 billion over the 2014–2023 period.

In addition, CBO estimates that establishing the VBP and APM programs with the opportunity for providers to choose to participate in only one of the programs would increase Medicare spending by $5.5 billion through 2023. That estimate largely reflects CBO's expectation that each provider will choose the program that is most attractive financially to that provider.

Other provisions in the bill would modify payment rates in certain California counties, adjust RVUs for certain physicians' services, require the development of payment codes that would encourage care coordination and the use of medical homes, and eliminate current-law penalties associated with not meeting quality or EHR standards. Those provisions would result in estimated net savings of $2.8 billion through 2023.

CBO's estimate of the budgetary effects of the legislation incorporates the effects of: changes in Medicare spending for services furnished in the fee-for-service sector on payments to Medicare Advantage (MA) plans; changes in receipts from premiums paid by beneficiaries; an increased likelihood that the Independent Payment Advisory Board (IPAB) mechanism would be triggered; and changes in spending by the Department of Defense's TRICARE program owing to changes in Medicare payment rates:

- Spending for the MA program would rise because the "benchmarks" that Medicare uses to determine how much the program pays for MA enrollees are adjusted for changes in Medicare spending per beneficiary in the fee-for-service sector. There would be no impact on MA spending under H.R. 2810 until 2016 because the payment rates currently in effect through March of 2014 will be used to set benchmarks for 2015. The effect on MA would account for about $42 billion of the total estimated increase in direct spending from the legislation over the 2015–2023 period.

• Beneficiaries enrolled in Part B of Medicare (which covers physicians' and other outpatient services) pay premiums that offset about 25 percent of the costs of those benefits. Such premium collections are recorded as offsetting receipts (a credit against direct spending). Therefore, about one-quarter of the gross increase in Medicare spending would be offset by changes in those premium receipts. Premiums for 2014 have been set, so changes to offsetting receipts for this legislation would begin in 2015. Over the 2015–2023 period, CBO estimates that aggregate Part B premium receipts would rise by about $35 billion.

• For 2015 and subsequent years, the IPAB is obligated to make changes to the Medicare program that will reduce spending if the rate of growth in spending per beneficiary is projected to exceed a target rate of growth linked to the consumer price index and per capita changes in nominal gross domestic product. CBO's projections of the rates of growth in spending per beneficiary in its May 2013 baseline are below the target rates of growth for fiscal years 2015 through 2023. However, enacting H.R. 2810 would increase Medicare spending, which would increase the likelihood that the IPAB mechanism would be triggered. CBO estimates the expected value of the savings from triggering the IPAB mechanism would be a $0.5 billion reduction in Medicare spending over the 2015–2023 period.

• The TRICARE program pays Medicare coinsurance and deductibles for military retirees. Those coinsurance and deductible payments would be higher under the legislation because the prices of physicians' services in Medicare would be higher. CBO estimates that the effect on TRICARE from the legislation would increase direct spending by about $1 billion over ten years.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go (S-PAYGO) Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues for the current year and ten years beginning with the budget year as defined by the Balanced Budget and Emergency Deficit Control Act. Beginning in January 2014, the budget year is fiscal year 2015, so the following S-PAYGO estimates go through 2024. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 2810, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON WAYS AND MEANS ON DECEMBER 12, 2013

	By fiscal year, in billions of dollars—												
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2014–2019	2014–2024
NET INCREASE IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	5.3	10.6	10.9	11.1	10.7	12.0	13.5	14.9	16.5	15.5	16.2	60.7	137.3

Estimated impact on state, local, and tribal governments: H.R. 2810 would shield health care providers from liability claims based on any federal guidelines or standards developed, recognized, or implemented under any health care provision of the Affordable Care Act. That provision would impose an intergovernmental mandate as defined in UMRA because it would preempt state laws that allow for the use of such guidelines or standards in medical mal-

practice claims. While the preemption would limit the application of state laws, CBO estimates that it would not impose significant costs and would fall well below the threshold established in UMRA for intergovernmental mandates ($76 million in 2014, adjusted annually for inflation).

Estimated impact on the private sector: This bill contains no new private-sector mandates as defined in UMRA.

Previous CBO estimate: On September 13, 2013, CBO estimated that enacting H.R. 2810 as ordered reported by the House Committee on Energy and Commerce on July 31, 2013, would cost about $175 billion over the 2014–2023 period. We have subsequently reduced that estimate to $146 billion, reflecting two final actions. First, the Centers for Medicare and Medicaid Services published a final rule that announced the update to the conversion factor for the physician fee schedule for 2014 and other current-law adjustments. The revised payment rates, as well as other information provided in the final rule, changed CBO's projections of Medicare payment rates for services provided on the physician fee schedule for 2014 and future years. Second, enactment of the Bipartisan Budget Act of 2013 temporarily sets updates to payment rates for services on the physician fee schedule to 0.5 percent from January 1, 2014, to March 31, 2014.

This estimate for the Ways and Means version of H.R. 2810 reflects both of those final actions. CBO's estimate for the version of H.R. 2810 approved by the Committee on Ways and Means is lower than CBO's estimate for the version of H.R. 2810 approved by the Committee on Energy and Commerce primarily because of lower annual updates to payment rates for services on the physician fee schedule and lower costs associated with payments made through APMs.

Estimate prepared by: Federal Costs: Lori Housman; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Alexia Diorio.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE OF REPRESENTATIVES

A. Committee Oversight Findings and Recommendations

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held hearings and made findings that are reflected in this report.

B. Statement of General Performance Goals and Objectives

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the performance goals and objectives of the Committee are reflected in the descriptive portions of this report.

C. Duplication of Federal Programs

No provision of the bill establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the

Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

D. INFORMATION RELATED TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Act of 1995 (Public Law 104–4). The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office.

E. APPLICABILITY TO HOUSE RULE XXI 5(b)

Clause 5(b) of rule XXI of the Rules of the House of Representatives provides, in part, that "A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present." The Committee states that the bill does not involve any Federal income tax rate increases within the meaning of the rule.

F. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee states that the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * * * *

PART A—GENERAL PROVISIONS

* * * * * * *

CENTER FOR MEDICARE AND MEDICAID INNOVATION

SEC. 1115A. (a) * * *

* * * * * * *

(b) TESTING OF MODELS (PHASE I).—

(1) * * *

(2) SELECTION OF MODELS TO BE TESTED.—

(A) * * *

(B) OPPORTUNITIES.—The models described in this subparagraph are the following models:

(i) * * *

* * * * * * *

(xxi) Focusing primarily on physicians' services (as defined in section 1848(j)(3)) furnished by physicians who are not primary care practitioners.

(xxii) Focusing on practices of fewer than 20 professionals.

(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

(i) * * *

* * * * * * *

(viii) Whether the model demonstrates effective linkage with [other public sector or private sector payers] *other public sector payers, private sector payers, or Statewide payment models*.

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

FREE CHOICE BY PATIENT GUARANTEED

SEC. 1802. (a) * * *

(b) USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.—

(1) * * *

* * * * * * *

(3) PHYSICIAN OR PRACTITIONER REQUIREMENTS.—

(A) * * *

(B) AFFIDAVIT.—An affidavit is described in this subparagraph if—

(i) * * *

(ii) the affidavit provides that the physician or practitioner will not submit any claim under this title for any item or service provided to any medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) [during the 2-year period beginning on the date the affidavit is signed] *during the applicable 2-year period (as defined in subparagraph (D))*; and

* * * * * * *

(C) ENFORCEMENT.—If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this title for any item or service provided [during the 2-year period described in subparagraph (B)(ii)] *during the applicable 2-year period* (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

(i) * * *

* * * * * * *

(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, the term "applicable 2-year period" means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.

* * * * * * *

(5) POSTING OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—

(A) IN GENERAL.—Beginning not later than February 1, 2015, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

(B) INFORMATION TO BE INCLUDED.—The information to be made available under subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

(i) Their number.

(ii) Their physician or professional specialty or other designation.

(iii) Their geographic distribution.

(iv) The timing of their becoming opt-out physicians and practitioners, relative to when they first entered practice and with respect to applicable 2-year periods.

(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.

[(5)**]** *(6)* DEFINITIONS.—In this subsection:

(A) * * *

* * * * * * *

(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—The term "opt-out physician or practitioner" means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

* * * * * * *

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) * * *

* * * * * * *

(16) MISCELLANEOUS PROVISIONS.—

(A) * * *

* * * * * * *

(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(p).

* * * * * * *

(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

(1) * * *

* * * * * * *

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. *The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.*

* * * * * * *

(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) * * *

* * * * * * *

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. *The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.*

* * * * * * *

(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

(1) PAYMENT INCENTIVE.—

(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2017 and ending with 2022 and for which the professional is a qualifying APM participant, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such pro-

fessional an amount equal to 5 percent of the payment amount for the covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases where payment for covered professional services furnished by a qualifying APM participant in an alternative payment model is made to an entity participating in the alternative payment model rather than directly to the qualifying APM participant.

(B) FORM OF PAYMENT.—Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

(D) COORDINATION.—The amount of the additional payment for an item or service under this subsection or subsection (m) shall be determined without regard to any additional payment for the item or service under subsection (m) and this subsection, respectively. The amount of the additional payment for an item or service under this subsection or subsection (x) shall be determined without regard to any additional payment for the item or service under subsection (x) and this subsection, respectively. The amount of the additional payment for an item or service under this subsection or subsection (y) shall be determined without regard to any additional payment for the item or service under subsection (y) and this subsection, respectively.

(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term "qualifying APM participant" means the following:

(A) 2017 AND 2018.—With respect to 2017 and 2018, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

(B) 2019 AND 2020.—With respect to 2019 and 2020, an eligible professional described in either of the following clauses:

(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attrib-

utable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

(ii) COMBINATION ALL-PAYER AND MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of law),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made under an eligible alternative payment model; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures.

(C) BEGINNING IN 2021.—With respect to 2021 and each subsequent year, an eligible professional described in either of the following clauses:

(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

(ii) COMBINATION ALL-PAYER AND MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of law),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made under an eligible alternative payment model; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures.

(2) ADDITIONAL DEFINITIONS.—In this subsection:

(A) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" has the meaning given that term in section 1848(k)(3)(A).

(B) ELIGIBLE PROFESSIONAL.—The term "eligible professional" has the meaning given that term in section 1848(k)(3)(B).

(C) ALTERNATIVE PAYMENT MODEL (APM).—The term "alternative payment model" means any of the following:

(i) A model under section 1115A (other than a health care innovation award).

(ii) An accountable care organization under section 1899.

(iii) A demonstration under section 1866C.

(iv) A demonstration required by Federal law.

(D) ELIGIBLE ALTERNATIVE PAYMENT MODEL (APM).—

(i) IN GENERAL.—The term "eligible alternative payment model" means, with respect to a year, an alternative payment model—

(I) that requires use of certified EHR technology (as defined in subsection (o)(4));

(II) that provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

(III) that satisfies the requirement described in clause (ii).

(ii) ADDITIONAL REQUIREMENT.—For purposes of clause (i)(III), the requirement described in this clause, with respect to a year and an alternative payment model, is that the alternative payment model—

(I) is one in which one or more entities bear financial risk for monetary losses under such model that are in excess of a nominal amount; or

(II) is a medical home expanded under section 1115A(c).

(3) LIMITATION.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an alternative payment model is an eligible alternative payment model under paragraph (3)(D).

(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) * * *

* * * * * * *

(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

(1) PROGRAM ESTABLISHED.—

(A) IN GENERAL.—The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term "appropriate use criteria" means criteria to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition. To the extent feasible, such criteria shall be evidence-based.

(C) APPLICABLE IMAGING SERVICE DEFINED.—In this subsection, the term "applicable imaging service" means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

(ii) there are one or more qualified clinical decision support mechanisms listed under paragraph (3)(C); and

(iii) one or more of such mechanisms is available free of charge.

(D) APPLICABLE SETTING DEFINED.—In this subsection, the term "applicable setting" means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other outpatient setting determined appropriate by the Secretary.

(E) ORDERING PROFESSIONAL DEFINED.—In this subsection, the term "ordering professional" means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who orders an applicable imaging service for an individual.

(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term "furnishing professional" means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service for an individual.

(2) ESTABLISHMENT OF APPLICABLE APPROPRIATE USE CRITERIA.—

(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other entities.

(B) CONSIDERATIONS.—In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

(i) have stakeholder consensus;

(ii) have been determined to be scientifically valid and are evidence based; and

(iii) are in the public domain.

(C) REVISIONS.—The Secretary shall periodically update and revise (as appropriate) such specification of applicable appropriate use criteria.

(D) TREATMENT OF MULTIPLE APPLICABLE APPROPRIATE USE CRITERIA.—In the case where the Secretary determines that more than one appropriate use criteria applies with respect to an applicable imaging service, the Secretary shall specify one or more applicable appropriate use criteria under this paragraph for the service.

(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(i) IN GENERAL.—The Secretary shall specify one or more qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, and other stakeholders in specifying mechanisms under this paragraph.

(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1848(o)(4)).

(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

(III) Use of a clinical decision support mechanism established by the Secretary.

(B) QUALIFIED CLINICAL DECISION SUPPORT MECHANISMS.—

(i) IN GENERAL.—For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

(ii) REQUIREMENTS.—The requirements described in this clause are the following:

(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

(II) In the case where there are more than one applicable appropriate use criteria specified under such paragraph for an applicable imaging service,

the mechanism indicates the criteria that it uses for the service.

(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

(VI) The mechanism meets privacy and security standards under applicable provisions of law.

(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(i) INITIAL LIST.—Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

(ii) PERIODIC UPDATING OF LIST.—The Secretary shall periodically update the list of qualified clinical decision support mechanisms specified under this paragraph.

(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(A) CONSULTATION BY ORDERING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

(i) consult with a qualified decision support mechanism listed under paragraph (3)(C); and

(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

(B) REPORTING BY FURNISHING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), payment for such service may only be made if the claim for the service includes the following:

(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

(ii) Information regarding—

(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

(II) whether the service ordered would not adhere to such criteria; or

(III) whether such criteria was not applicable to the service ordered.

(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

(i) EMERGENCY SERVICES.—An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1867(e)(1)).

(ii) INPATIENT SERVICES.—An applicable imaging service ordered for an inpatient and for which payment is made under part A.

(iii) ALTERNATIVE PAYMENT MODELS.—An applicable imaging service ordered by an ordering professional with respect to an individual attributed to an alternative payment model (as defined in section 1833(z)(3)(C)).

(iv) SIGNIFICANT HARDSHIP.—An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

(D) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term "applicable payment system" means the following:

(i) The physician fee schedule established under section 1848(b).

(ii) The prospective payment system for hospital outpatient department services under section 1833(t).

(iii) The ambulatory surgical center payment systems under section 1833(i).

(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on a periodic basis (which may be annually), ordering professionals who are outlier ordering professionals.

(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

(D) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

(B) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.

(q) ESTABLISHMENT OF APPROPRIATE USE PROGRAM FOR OTHER PART B SERVICES.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary may establish an appropriate use program for services under this part (other than applicable imaging services under subsection (p)) using a process similar to the process under such subsection.

(B) REQUIREMENTS.—In determining whether to establish a program under subparagraph (A), the Secretary shall take into consideration—

(i) the implementation of appropriate use criteria for applicable imaging services under subsection (p); and

(ii) the report under paragraph (2).

(C) INPUT FROM STAKEHOLDERS IN ADVANCE OF RULEMAKING.—Before issuing a notice of proposed rulemaking to establish a program under subparagraph (A), the Secretary shall issue an advance notice of proposed rulemaking.

(2) REPORT ON EXPERIENCE OF IMAGING APPROPRIATE USE CRITERIA PROGRAM.—Not later than 18 months after the date of the enactment of this subsection, the Comptroller General of the United States shall submit to Congress a report that includes a description of the extent to which appropriate use criteria could be used for other services under this part, such as radiation therapy and clinical diagnostic laboratory services.

* * * * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) * * *

* * * * * * *

(7) INCENTIVES FOR MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—Subject to subparagraphs (B) and (D), with respect to covered professional services furnished by an eligible professional during 2015 [or any subsequent payment year] *or 2016*, if the eligible professional is not a meaningful EHR user (as determined under subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) APPLICABLE PERCENT.— [Subject to clause (iii), for] *For* purposes of clause (i), the term "applicable percent" means—

(I) for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under section 1848(a)(5) for 2014, 98 percent); *and*

(II) for 2016, 98 percent[; and].

[(III) for 2017 and each subsequent year, 97 percent.]

[(iii) AUTHORITY TO DECREASE APPLICABLE PERCENTAGE FOR 2018 AND SUBSEQUENT YEARS.—For 2018 and each subsequent year, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users (as determined under subsection (o)(2)) is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case shall the applicable percent be less than 95 percent.]

* * * * * * *

(8) INCENTIVES FOR QUALITY REPORTING.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during 2015 [or any subsequent year] *or 2016*, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term "applicable percent" means—

(I) * * *

(II) for 2016 [and each subsequent year], 98 percent.

* * * * * * *

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) * * *

* * * * * * *

(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

(A) IN GENERAL.—In order to encourage the management of care by an applicable provider (as defined in subparagraph (B)) for individuals with chronic care needs the Secretary shall—

(i) establish one or more HCPCS codes for chronic care management services for such individuals; and

(ii) subject to subparagraph (D), make payment (as the Secretary determines to be appropriate) under this section for such management services furnished on or after January 1, 2015, by an applicable provider.

(B) APPLICABLE PROVIDER DEFINED.—For purposes of this paragraph, the term "applicable provider" means a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), or clinical nurse specialist (as defined in section 1861(aa)(5)(B)) who furnishes services as part of a patient-centered medical home or a comparable specialty practice that—

(i) is recognized as such a medical home or comparable specialty practice by an organization that is recognized by the Secretary for purposes of such recognition as such a medical home or practice; or

(ii) meets such other comparable qualifications as the Secretary determines to be appropriate.

(C) BUDGET NEUTRALITY.—The budget neutrality provision under subsection (c)(2)(B)(ii)(II) shall apply in establishing the payment under subparagraph (A)(ii).

(D) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

(i) make payment to only one applicable provider for such services furnished to an individual during a period;

(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services (such as in the case of hospice care or home health services); and

(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) * * *

(2) DETERMINATION OF RELATIVE VALUES.—

(A) * * *

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) * * *

(ii) ADJUSTMENTS.—

(I) IN GENERAL.—The Secretary shall, to the extent the Secretary determines to be necessary and subject to [subclause (II)] *subclause (II) and paragraph (7)*, adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

* * * * * * *

(v) EXEMPTION OF CERTAIN REDUCED EXPENDITURES FROM BUDGET-NEUTRALITY CALCULATION.—The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

(I) * * *

* * * * * * *

(VIII) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2015, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).

* * * * * * *

(C) COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS.—For purposes of this section for each physicians' service—

(i) WORK RELATIVE VALUE UNITS.—The Secretary shall determine a number of work relative value units for [the service] *the service or group of services* based on the relative resources incorporating physician time and intensity required in furnishing [the service] *the service or group of services*.

(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS.—The Secretary shall determine a number of practice expense relative value units for the service for years before 1999 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)),

and for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service *or group of services*. For 1999, such number of units shall be determined based 75 percent on such

product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.

(iii) MALPRACTICE RELATIVE VALUE UNITS.—The Secretary shall determine a number of malpractice relative value units for [the service] *the service or group of services* for years before 2000 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for [the service] *the service or group of services*, and

(II) the malpractice percentage for [the service] *the service or group of services* (as determined under paragraph (3)(C)(iii)),

and for years beginning with 2000 based on the malpractice expense resources involved in furnishing [the service] *the service or group of services*.

* * * * * * *

(K) POTENTIALLY MISVALUED CODES.—

(i) * * *

[(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called "Harvard-valued codes"); and such other codes determined to be appropriate by the Secretary.]

(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

(I) Codes that have experienced the fastest growth.

(II) Codes that have experienced substantial changes in practice expenses.

(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

(VI) Codes that have not been subject to review since implementation of the fee schedule.

(VII) Codes that account for the majority of spending under the physician fee schedule.

(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

(XI) Codes for which there may be anomalies in relative values within a family of codes.

(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

(XIII) Codes with high intra-service work per unit of time.

(XIV) Codes with high practice expense relative value units.

(XV) Codes with high cost supplies.

(XVI) Codes as determined appropriate by the Secretary.

(iii) REVIEW AND ADJUSTMENTS.—

(I) * * *

* * * * * * *

(VI) The **[**provisions of subparagraph (B)(ii)(II)**]** *provisions of subparagraph (B)(ii)(II) and paragraph (7)* shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments **[**under subparagraph (B)(ii)(II)**]** *under subparagraph (B)(ii)(I)*.

* * * * * * *

(M) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

(i) COLLECTION OF INFORMATION.—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indi-

rectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

(ii) USE OF INFORMATION.—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

(iii) TYPES OF INFORMATION.—The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

(I) Time involved in furnishing services.

(II) Amounts and types of practice expense inputs involved with furnishing services.

(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

(IV) Overhead and accounting information for practices of physicians and other suppliers.

(V) Any other element that would improve the valuation of services under this section.

(iv) INFORMATION COLLECTION MECHANISMS.—Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

(II) Surgical logs, billing systems, or other practice or facility records.

(III) Electronic health records.

(IV) Any other mechanism determined appropriate by the Secretary.

(v) TRANSPARENCY OF USE OF INFORMATION.—

(I) IN GENERAL.—Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

(II) THRESHOLDS FOR USE.—The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

(III) DISCLOSURE OF INFORMATION.—The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or infor-

mation collected or obtained pursuant to a non-disclosure agreement.

(vi) INCENTIVE TO PARTICIPATE.—The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

(vii) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information collected or obtained under this subparagraph.

(viii) DEFINITION OF ELIGIBLE PROFESSIONAL.—In this subparagraph, the term "eligible professional" has the meaning given such term in subsection (k)(3)(B).

(ix) FUNDING.—For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.

(N) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).

(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2015 through 2018, the following shall apply:

(i) DETERMINATION OF NET REDUCTION IN EXPENDITURES.—For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

(ii) BUDGET NEUTRAL REDISTRIBUTION OF FUNDS IF TARGET MET AND COUNTING OVERAGES TOWARDS THE TARGET FOR THE SUCCEEDING YEAR.—If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in

clause (i) for the succeeding year, for purposes of determining whether the target has or has not been met under this subparagraph with respect to that year.

(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2015.

(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

(I) the target for the year; and

(II) the estimated net reduction in expenditures determined under clause (i) for the year.

(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent of the estimated amount of expenditures under the fee schedule under this section for the year.

* * * * * * *

(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2015, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4) *or a subsequent paragraph*) for the year involved.

* * * * * * *

(4) UPDATE FOR YEARS BEGINNING WITH 2001 *AND ENDING WITH 2013*.—

(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 *and ending with 2013* is equal to the product of—

(i) * * *

* * * * * * *

(15) UPDATE FOR 2014 THROUGH 2016.—The update to the single conversion factor established in paragraph (1)(C) for each of 2014 through 2016 shall be 0.5 percent.

(16) UPDATE FOR 2017 THROUGH 2023.—The update to the single conversion factor established in paragraph (1)(C) for each of 2017 through 2023 shall be zero percent.

(17) UPDATE FOR 2024 AND SUBSEQUENT YEARS.—The update to the single conversion factor established in paragraph (1)(C) for 2024 and each subsequent year shall be—

(A) for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) for such year, 2 percent; and

(B) for other items and services, 1 percent.

(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

(1) * * *

* * * * * * *

(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an "MSA"), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

(I) for 2017, is 5/6; and

(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

(D) TRANSITION AREA DEFINED.—In this paragraph, the term "transition area" means each of the following fee schedule areas for 2013:

(i) The rest-of-State payment locality.

(ii) Payment locality 3.

(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.

(f) SUSTAINABLE GROWTH RATE.—

(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

(A) * * *

(B) November 1 of each succeeding year *through 2013* the sustainable growth rate for such succeeding year and each of the preceding 2 years.

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 *and ending with 2013* shall be equal to the product of—

(A) * * *

* * * * * * *

(i) MISCELLANEOUS PROVISIONS.—

(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

(A) * * *

* * * * * * *

(D) the establishment of geographic adjustment factors under subsection (e), **[**and**]**

(E) the establishment of the system for the coding of physicians' services under this section**[**.**]**, *and*

(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).

* * * * * * *

(j) DEFINITIONS.—In this section:

(1) * * *

(2) FEE SCHEDULE AREA.— [The term] *Except as provided in subsection (e)(6)(D), the term* "fee schedule area" means a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services.

* * * * * * *

(k) QUALITY REPORTING SYSTEM.—
(1) * * *

* * * * * * *

(9) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection for purposes of subsection (q).

* * * * * * *

(m) INCENTIVE PAYMENTS FOR QUALITY REPORTING.—
(1) * * *

* * * * * * *

(3) SATISFACTORY REPORTING AND SUCCESSFUL ELECTRONIC PRESCRIBER AND DESCRIBED.—
(A) * * *

* * * * * * *

(C) SATISFACTORY REPORTING MEASURES FOR GROUP PRACTICES.—
(i) * * *
(ii) STATISTICAL SAMPLING MODEL.—The process under clause (i) shall provide *and, for 2014 and subsequent years, may provide* for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1866A.

* * * * * * *

(D) SATISFACTORY REPORTING MEASURES THROUGH PARTICIPATION IN A QUALIFIED CLINICAL DATA REGISTRY.—For 2014 and subsequent years, the Secretary shall treat an eligible professional as satisfactorily submitting data on quality measures under subparagraph (A) *and, for 2015 and subsequent years, subparagraph (A) or (C)* if, in lieu of reporting measures under subsection (k)(2)(C), the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry (as described in subparagraph (E)) for the year.
(E) QUALIFIED CLINICAL DATA REGISTRY.—
(i) * * *

* * * * * * *

(vi) ACCESS TO MEDICARE DATA TO FACILITATE QUALITY IMPROVEMENT.—

(I) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, and subject to other requirements as the Secretary may specify, beginning July 1, 2014, the Secretary shall, if requested by a qualified clinical data registry under this subparagraph, subject

to subclauses (II) and (III), provide data as described in section 1874(e)(3) (in a form and manner determined to be appropriate) to such registry for purposes of linking such data with clinical data and performing analyses and research to support quality improvement or patient safety.

(II) PROTECTION.—A qualified clinical data registry may not publicly report any data made available under subclause (I) (or any analyses or research described in such subclause) that individually identifies a provider of services, supplier, or individual unless the registry obtains the consent of such provider, supplier, or individual prior to such reporting.

(III) FEE.—The data described in subclause (I) shall be made available to qualified clinical data registries at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited in the Centers for Medicare & Medicaid Services Program Management Account.

* * * * * * *

(5) APPLICATION.—

(A) * * *

* * * * * * *

(F) EXTENSION.—For 2008 [and subsequent years] *through reporting periods occurring in 2013*, the Secretary shall establish *and, for reporting periods occurring in 2014 and subsequent years, the Secretary may establish* alternative criteria for satisfactorily reporting under this subsection and alternative reporting periods under paragraph (6)(C) for reporting groups of measures under subsection (k)(2)(B) and for reporting using the method specified in subsection (k)(4).

* * * * * * *

[(7)] *(8)* ADDITIONAL INCENTIVE PAYMENT.—

(A) * * *

* * * * * * *

(9) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection for purposes of subsection (q).

(n) PHYSICIAN FEEDBACK PROGRAM.—

(1) * * *

* * * * * * *

(11) REPORTS ENDING WITH 2016.—Reports under the Program shall not be provided after December 31, 2016. See subsection (q)(13) for reports beginning with 2017.

(o) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) * * *

(2) MEANINGFUL EHR USER.—

(A) IN GENERAL.—[For purposes of paragraph (1), an] *An* eligible professional shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (a)(7), for an EHR reporting period under such subsection for a year*, or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year*) if each of the following requirements is met:

(i) * * *

(ii) INFORMATION EXCHANGE.—The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination*, and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation similar to that required in the health information technology donation safe harbor established under regulations under section 1128B(b)(3)(E)) that the professional has not and will not take any deliberate action to limit or restrict the use, compatibility, or interoperability of the certified EHR technology*.

(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) *and subsection (q)(5)(C)(ii)(II)* and using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

* * * * * * *

(D) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—With respect to 2017 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a VBP eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year.

* * * * * * *

(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

(1) * * *

(2) QUALITY.—

(A) * * *

* * * * * * *

(C) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).

(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary. *With respect to 2017 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).*

(4) IMPLEMENTATION.—

(A) * * *

(B) DEADLINES FOR IMPLEMENTATION.—

(i) * * *

* * * * * * *

[(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

[(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

[(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.**]**

(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, but before January 1, 2017, with respect to specific physicians and groups of physicians the Secretary determines appropriate. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2017.

* * * * * * *

(q) VALUE-BASED PERFORMANCE INCENTIVE PROGRAM.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional value-based performance incentive program (in this subsection referred to as the "VBP program") under which the Secretary shall—

(i) develop a methodology for assessing the total performance of each VBP eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

(iii) use such composite performance score of the VBP eligible professional for a performance period for a year to make VBP program incentive payments under paragraph (7) to the professional for the year.

(B) PROGRAM IMPLEMENTATION.—The VBP program shall apply to payments for items and services furnished on or after January 1, 2017.

(C) VBP ELIGIBLE PROFESSIONAL DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iv), the term "VBP eligible professional" means—

(I) for the first and second years for which the VBP program applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)(1)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and

(II) for the third year for which the VBP program applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I) and such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

(ii) EXCLUSIONS.—For purposes of clause (i), the term "VBP eligible professional" does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B))—

(I) who is a qualifying APM participant (as defined in section 1833(z)(2));

(II) who, subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the VBP program; or

(III) who, for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

(iii) PARTIAL QUALIFYING APM PARTICIPANT.—For purposes of this subparagraph, the term "partial qualifying APM participant" means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1833(z) for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

(I) with respect to 2017 and 2018, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

(II) with respect to 2019 and 2020—

(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph were instead references to 40 percent and 20 percent, respectively; and

(III) with respect to 2021 and subsequent years—

(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph were instead references to 50 percent and 20 percent, respectively.

(iv) SELECTION OF LOW-VOLUME THRESHOLD MEASUREMENT.—The Secretary shall select one of the following low-volume threshold measurements to apply for purposes of clause (ii)(III):

(I) The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the VBP eligible professional for the performance period involved.

(II) The minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.

(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.

(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a VBP eligible professional until the subsequent year and performance period for such subsequent year.

(vi) CLARIFICATION.—In the case of items and services furnished during a year by an individual who is not a VBP eligible professional (including pursuant to clauses (ii) and (v)) with respect to a year, in no case shall a reduction under paragraph (6) or a VBP program incentive payment under paragraph (7) apply to such individual for such year.

(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATION.—In the case of an eligible professional who is a partial qualifying APM participant, with respect to

a year, and who for the performance period for such year reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the VBP program, such eligible professional is considered to be a VBP eligible professional with respect to such year.

(D) APPLICATION TO GROUP PRACTICES.—

(i) IN GENERAL.—Under the VBP program:

(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for VBP eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for VBP eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

(ii) ENSURING COMPREHENSIVENESS OF GROUP PRACTICE ASSESSMENT.—The process established under clause (i) shall to the extent practicable reflect the full range of items and services furnished by the VBP eligible professionals in the group practice involved.

(iii) CLARIFICATION.—VBP eligible professionals electing to be a virtual group under paragraph (5)(J) shall not be considered VBP eligible professionals in a group practice for purposes of applying this subparagraph.

(E) USE OF REGISTRIES.—Under the VBP program, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

(F) APPLICATION OF CERTAIN PROVISIONS.—In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

(2) MEASURES AND ACTIVITIES UNDER PERFORMANCE CATEGORIES.—

(A) PERFORMANCE CATEGORIES.—Under the VBP program, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

(i) Quality.

(ii) Resource use.

(iii) Clinical practice improvement activities.

(iv) Meaningful use of certified EHR technology.

(B) MEASURES AND ACTIVITIES SPECIFIED FOR EACH CATEGORY.—For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

(i) QUALITY.—For the performance category described in subparagraph (A)(i), the quality measures established for such period under subsections (k) and (m), including under subsection (m)(3)(E), and the measures of quality of care established for such period under subsection (p)(2).

(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r), as appropriate, and, as feasible and applicable, accounting for the cost of covered part D drugs.

(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities under subcategories specified by the Secretary for such period, which shall include at least the following:

(I) The subcategory of expanded practice access, which shall include activities such as same day appointments for urgent needs and after hours access to clinician advice.

(II) The subcategory of population management, which shall include activities such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

(III) The subcategory of care coordination, which shall include activities such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

(IV) The subcategory of beneficiary engagement, which shall include activities such as the establishment of care plans for individuals with complex care needs, beneficiary self-management training, and using shared decision-making mechanisms.

(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of fewer than 20 professionals) and practices located in rural areas and in

health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

(C) ADDITIONAL PROVISIONS.—

(i) EMPHASIZING OUTCOME MEASURES UNDER QUALITY PERFORMANCE CATEGORY.—In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The Secretary may use measures used for a payment system other than for physicians for purposes of the performance category described in subparagraph (A)(i).

(iii) GLOBAL AND POPULATION-BASED MEASURES.—The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

(iv) REQUEST FOR INFORMATION FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders for identifying activities described in such subparagraph and specifying criteria for such activities.

(v) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY.—In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

(I) identifying activities described in subparagraph (B)(iii);

(II) specifying criteria for such activities; and

(III) determining whether a VBP eligible professional meets such criteria.

(vi) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PROVIDERS.—In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically provide services that do not involve face-to-face interaction with a patient; and

(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to VBP eligible professionals of such professional types or subcategories, in lieu of such a measure or activity, a comparable measure or activity that fulfills the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

(3) PERFORMANCE STANDARDS.—

(A) ESTABLISHMENT.—Under the VBP program, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

(B) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall take into account the following:

(i) Historical performance standards.

(ii) Improvement rates.

(iii) The opportunity for continued improvement.

(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with the year described in paragraph (1)(B)). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

(5) COMPOSITE PERFORMANCE SCORE.—

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and consistent with section 2(g)(2) of the SGR Repeal and Medicare Beneficiary Access Act of 2013, the Secretary shall develop a methodology for assessing the total performance of each VBP eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (in this subsection referred to as the "composite performance score") for each such professional for each performance period.

(B) WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), the Secretary—

(i) may assign different scoring weights (including a weight of 0) for—

(I) each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

(II) each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable to the type of eligible professional involved; and

(ii) with respect to the performance category described in paragraph (2)(A)(i)—

(I) shall assign a higher scoring weight to outcomes measures than to other measures and in-

crease the scoring weight for outcome measures over time; and

(II) may assign a higher scoring weight to patient experience measures.

(C) INCENTIVE TO REPORT; ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—

(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a VBP eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

(ii) ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—Under the methodology established under subparagraph (A), the Secretary shall—

(I) encourage VBP eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology; and

(II) with respect to a performance period, with respect to a year, for which a VBP eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

(D) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE.—

(i) RULE FOR ACCREDITATION.—A VBP eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice pursuant to subsection (b)(8)(B)(i) with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

(ii) APM PARTICIPATION.—Participation by a VBP eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn such eligible professional one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period. Nothing in the previous sentence shall prevent such professional from earning more than one-half of such highest potential score for such performance period by performing additional activities with respect to such performance category.

(iii) SUBCATEGORIES.—A VBP eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

(E) DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in a continuous distribution of performance scores, which shall result in differential payments under paragraph (7).

(F) ACHIEVEMENT AND IMPROVEMENT.—

(i) TAKING INTO ACCOUNT IMPROVEMENT.—Beginning with the second year to which the VBP program applies, in addition to the achievement score of a VBP eligible professional, the methodology developed under subparagraph (A)—

(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), shall take into account the improvement of the professional; and

(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT.—Beginning with the fourth year to which the VBP program applies, under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (B) with respect to the achievement score of a VBP eligible professional with respect to a measure or activity specified under paragraph (2)(B) (or with respect to such a measure or activity and with respect to categories described in paragraph (2)(A)) than to any improvement score applied under clause (i) with respect to such measure or activity (or such measure or activity and categories).

(G) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

(i) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to clauses (ii) and (iii), the composite performance score shall be determined as follows:

(I) QUALITY.—

(aa) IN GENERAL.—Subject to item (bb), 30 percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A).

(bb) FIRST 2 YEARS AND TEST YEAR.—For the first and second years for which the VBP program applies to payments, 60 percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). With respect to the subsequent year, the percent described in item (aa) of such score shall be based on performance with respect to such category only for purposes of feedback and 60 percent of such score shall be based on performance with respect to such category for any other purpose under this subsection.

(II) RESOURCE USE.—

(aa) IN GENERAL.—Subject to item (bb), 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

(bb) FIRST 2 YEARS AND TEST YEAR.—For the first and second years for which the VBP program applies to payments, zero percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). With respect to the subsequent year, the percent described in item (aa) of such score shall be based on performance with respect to such category only for purposes of feedback and zero percent of such score shall be based on performance with respect to such category for any other purpose under this subsection.

(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year (or, in the case of a year described in clause (i)(II)(bb), applicable under one or more of subclauses (I) and (III)) shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

(iii) AUTHORITY TO ADJUST PERCENTAGES FOR QUALITY AND RESOURCE USE.—Other than for a year described in clause (i)(II)(bb), the percentages described in subclauses (I) and (II) of clause (i), including after application of clause (ii), shall be equal.

(H) RESOURCE USE.—Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

(I) INCLUSION OF QUALITY MEASURE DATA FROM MULTIPLE PAYERS.—In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph

(2)(A)(i) may include data submitted by VBP eligible professionals with respect to multiple payers.

(J) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES.—

(i) IN GENERAL.—In the case of VBP eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A)—

(I) the assessment of performance provided under such methodology with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A) that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

(II) the composite score provided under this paragraph for such performance period with respect to each such performance category for each such VBP eligible professional in such virtual group shall be based on the assessment of the combined performance under subclause (I) for the performance category and performance period.

(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Secretary shall, in accordance with clause (iii), establish and have in place a process to allow an individual VBP eligible professional or a group practice consisting of not more than 10 VBP eligible professionals to elect, with respect to a performance period for a year, for such individual VBP eligible professional or all such VBP eligible professionals in such group practice, respectively, to be a virtual group under this subparagraph with at least one other such individual VBP eligible professional or group practice making such an election.

(iii) REQUIREMENTS.—The process under clause (ii) shall provide that—

(I) an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period; and

(II) a practice described in such clause, and each VBP eligible professional in such practice, may elect to be in no more than one virtual group for a performance period.

(6) FUNDING FOR VBP PROGRAM INCENTIVE PAYMENTS.—

(A) TOTAL AMOUNT FOR INCENTIVE PAYMENTS.—The total amount for VBP program incentive payments under paragraph (7) for all VBP eligible professionals for a year shall be equal to the total amount of the performance funding pool for all VBP eligible professionals under subparagraph (B) for such year, as estimated by the Secretary.

(B) PERFORMANCE FUNDING POOL.—

(i) IN GENERAL.—In the case of items and services furnished by a VBP eligible professional during a year (beginning with 2017), the otherwise applicable fee schedule amount (as defined in clause (iii)) with respect to such items and services and eligible professional for such year shall be reduced by the applicable percent under clause (ii). The total amount of such reductions for a year shall be referred to in this subsection as the "performance funding pool" for such year.

(ii) APPLICABLE PERCENT DEFINED.—For purposes of clause (i), the term "applicable percent" means—

(I) for 2017, 4 percent;

(II) for 2018, 6 percent;

(III) for 2019, 8 percent;

(IV) for 2020, 10 percent; and

(V) for 2021 and subsequent years, a percent specified by the Secretary (but in no case less than 10 percent or more than 12 percent).

(iii) OTHERWISE APPLICABLE FEE SCHEDULE AMOUNT.—For purposes of this subparagraph and paragraph (7), the term "otherwise applicable fee schedule amount" means, with respect to items and services furnished by a VBP eligible professional during a year, the fee schedule amount for such items and services and year that would otherwise apply (without application of this subparagraph or paragraph (7)) with respect to such eligible professional under subsection (b), after application of subsection (a)(3), or under another fee schedule under this part.

(7) VBP PROGRAM INCENTIVE PAYMENTS.—

(A) VBP PROGRAM INCENTIVE PAYMENT ADJUSTMENT FACTOR.—Consistent with section 2(g)(2) of the SGR Repeal and Medicare Beneficiary Access Act of 2013, the Secretary shall specify a VBP program incentive payment adjustment factor for each VBP eligible professional for a year. Such VBP program incentive payment adjustment factor for a VBP eligible professional for a year shall be determined—

(i) by the composite performance score of the eligible professional for such year;

(ii) in a manner such that the adjustment factors specified under this subparagraph for a year results in differential payments under this paragraph reflecting the full range of the distribution of composite performance scores of VBP eligible professionals determined under paragraph (5)(E) for such year, with such professionals having higher composite performance scores receiving higher payment; and

(iii) in a manner such that the adjustment factors specified under this subparagraph for a year—

(I) does not result in a payment reduction for such year by an amount that exceeds the applicable percent described in paragraph (6)(B)(ii) for such year; and

(II) does not result in a payment increase for such year by an amount that exceeds the applicable percent described in paragraph (6)(B)(ii) for such year.

(B) CALCULATION OF VBP PROGRAM INCENTIVE PAYMENT AMOUNTS.—The VBP program incentive payment amount with respect to items and services furnished by a VBP eligible professional during a year shall be equal to the difference between—

(i) the product of—

(I) the VBP program incentive payment adjustment factor determined under subparagraph (A) for such VBP eligible professional for such year; and

(II) the otherwise applicable fee schedule amount (as defined in paragraph (6)(B)(iii)) with respect to such items and services and eligible professional for such year; and

(ii) the otherwise applicable fee schedule amount, as reduced under paragraph (6)(B), with respect to such items and services, eligible professional, and year.

The application of the preceding sentence may result in the VBP program incentive payment amount being 0.0 with respect to an item or service furnished by a VBP eligible professional.

(C) APPLICATION OF VBP PROGRAM INCENTIVE PAYMENT AMOUNT.—In the case of items and services furnished by a VBP eligible professional during a year (beginning with 2017), the otherwise applicable fee schedule amount, as reduced under paragraph (6)(B), with respect to such items and services and eligible professional for such year shall be increased, if applicable, by the VBP program incentive payment amount determined under subparagraph (B) with respect to such items and services, professional, and year.

(D) BUDGET NEUTRALITY.—In specifying the VBP program incentive payment adjustment factor for each VBP eligible professional for a year under subparagraph (A), the Secretary shall ensure that the total amount of VBP program incentive payment amounts under this paragraph for all VBP eligible professionals in a year shall be equal to the performance funding pool for such year under paragraph (6), as estimated by the Secretary.

(8) ANNOUNCEMENT OF RESULT OF ADJUSTMENTS.—Under the VBP program, the Secretary shall, not later than 60 days prior to the year involved, make available to each VBP eligible professional the VBP program incentive payment adjustment factor under paragraph (7) and the payment reduction under paragraph (6) applicable to the eligible professional for items and services furnished by the professional in such year. The Secretary may include such information in the confidential feedback under paragraph (13).

(9) NO EFFECT IN SUBSEQUENT YEARS.—The VBP program incentive payment under paragraph (7) and the payment reduction under paragraph (6) shall each apply only with respect to the year involved, and the Secretary shall not take into account

such VBP program incentive payment or payment reduction in making payments to a VBP eligible professional under this part in a subsequent year.

(10) PUBLIC REPORTING.—

(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website under subsection (t) the following:

(i) Information regarding the performance of VBP eligible professionals under the VBP program, which—

(I) shall include the composite score for each such VBP eligible professional and the performance of each such VBP eligible professional with respect to each performance category; and

(II) may include the performance of each such VBP eligible professional with respect to each measure or activity specified in paragraph (2)(B).

(ii) The names of eligible professionals in eligible alternative payment models (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

(D) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the VBP program, including the range of composite scores for all VBP eligible professionals and the range of the performance of all VBP eligible professionals with respect to each performance category.

(11) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the VBP program, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (7). Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

(12) TECHNICAL ASSISTANCE TO SMALL PRACTICES AND PRACTICES IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to VBP eligible professionals in practices of fewer than 20 professionals (with priority given to such

practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of the Public Health Service Act), or practices with low composite scores) with respect to—

(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C).

(B) FUNDING FOR IMPLEMENTATION.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of $50,000,000 for each of fiscal years 2014 through 2018. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

(13) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

(A) PERFORMANCE FEEDBACK.—

(i) IN GENERAL.—Beginning July 1, 2015, the Secretary—

(I) shall make available timely (such as quarterly) confidential feedback to each VBP eligible professional on the performance of such professional with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

(II) may make available confidential feedback to each such professional on the performance of such professional with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. The Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (m)(3)(E)).

(iii) USE OF DATA.—For purposes of clause (i), the Secretary may use data, with respect to a VBP eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

(iv) DISCLOSURE EXEMPTION.—Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5, United States Code.

(v) RECEIPT OF INFORMATION.—The Secretary may use the mechanisms established under clause (ii) to receive information from professionals, such as information with respect to this subsection.

(B) ADDITIONAL INFORMATION.—

(i) IN GENERAL.—Beginning July 1, 2016, the Secretary shall make available to each VBP eligible professional information, with respect to individuals who are patients of such VBP eligible professional, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information shall be made available under the previous sentence to such VBP eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information shall be made available in accordance with the same or similar terms as data are made available to accountable care organizations under section 1899, including a beneficiary opt-out.

(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title and that are furnished to individuals, who are patients of a VBP eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

(II) Historical averages (and other measures of the distribution if appropriate) of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary) for care episodes for such period.

(14) REVIEW.—

(A) TARGETED REVIEW.—The Secretary shall establish a process under which a VBP eligible professional may seek an informal review of the calculation of the VBP program incentive payment adjustment factor applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (7) with respect to a year (other than with respect to the calculation of such eligible professional's VBP program incentive payment adjustment factor for such year) after the factors determined in subparagraph (A) of such paragraph have been determined for such year.

(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

(i) The methodology used to determine the amount of the VBP program incentive payment adjustment factor

under paragraph (7) and the determination of such amount.

(ii) The determination of the amount of funding available for such VBP program incentive payments under paragraph (6)(A) and the payment reduction under paragraph (6)(B)(i).

(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iv) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (10).

(v) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

(r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the value-based performance incentive program under subsection (q) and alternative payment models under section 1833(z), the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

(2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

(A) IN GENERAL.—In order to classify similar patients into distinct care episode groups and distinct patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 60 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 60 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

(i) distinct care episode groups; and

(ii) distinct patient condition groups.

(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the informa-

tion received under subparagraph (C), the Secretary shall—

(I) establish distinct care episode groups and distinct patient condition groups, which account for at least an estimated two-thirds of expenditures under parts A and B; and

(II) assign codes to such groups.

(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization is anticipated or occurs, and the principal procedures or services planned or furnished; and

(II) other factors determined appropriate by the Secretary.

(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical history at the time of each medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 120 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 120 days after the end of the comment period described in subpara-

graph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2016), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.

(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 120 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2016), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2016, shall, as determined appropriate by the Secretary, include—

(A) applicable codes established under paragraphs (2) and (3); and

(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall—

(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients), as the Secretary determines appropriate.

(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

(ii) use the claims data experience of such patients by care episode codes—

(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

(i) shall use per patient total allowed amounts for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

(ii) may, as determined appropriate, use other measures of allowed amounts (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

(6) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

(A) care episode and patient condition groups and codes established under paragraph (2);

(B) patient relationship categories and codes established under paragraph (3); and

(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(8) DEFINITIONS.—In this section:

(A) PHYSICIAN.—The term "physician" has the meaning given such term in section 1861(r)(1).

(B) APPLICABLE PRACTITIONER.—The term "applicable practitioner" means—

(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)); and

(ii) beginning January 1, 2017, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

(9) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.

(s) PRIORITIES AND FUNDING FOR QUALITY MEASURE DEVELOPMENT.—

(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

(A) DRAFT MEASURE DEVELOPMENT PLAN.—

(i) DRAFT PLAN.—

(I) IN GENERAL.—Not later than October 1, 2014, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions.

(II) REQUIREMENT.—Such plan shall address how measures used by private payers and integrated delivery systems could be incorporated under such subsection.

(ii) CONSIDERATION.—In developing the draft plan under subparagraph (A), the Secretary shall consider—

(I) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities; and

(II) whether measures are applicable across health care settings.

(iii) PRIORITIES.—In developing the draft plan under subparagraph (A), the Secretary shall give priority to the following types of measures:

(I) Outcome measures including patient reported outcome and functional status measures.

(II) Patient experience measures.

(III) Care coordination measures.

(IV) Measures of appropriate use of services, including measures of over use.

(iv) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term "applicable provisions" means the following provisions:

(I) Subsection (q)(2)(B)(i).

(II) Section 1833(z)(2)(C).

(B) STAKEHOLDER INPUT.—The Secretary shall accept through December 1, 2014, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

(C) OPERATIONAL MEASURE DEVELOPMENT PLAN.—Not later than February 1, 2015, taking into account the comments received under subparagraph (B), the Secretary shall

post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under subsection (q)(2)(A)(i).

(2) CONTRACTS AND OTHER ARRANGEMENTS FOR QUALITY MEASURE DEVELOPMENT.—

(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding quality measures for application under the applicable provisions. Such entities may include physician specialty societies and other practitioner organizations.

(B) PRIORITIZATION.—

(i) IN GENERAL.—In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(A)(iii).

(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider whether such measures would be electronically specified.

(3) ANNUAL REPORT BY THE SECRETARY.—

(A) IN GENERAL.—Not later than February 1, 2016, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

(B) REQUIREMENTS.—Each report submitted pursuant to paragraph (1) shall include the following:

(i) A description of the Secretary's efforts to implement this subsection.

(ii) With respect to the measures developed during the previous year—

(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

(II) the name of each measure developed;

(III) the name of the developer and steward of each measure;

(IV) with respect to each type of measure, an estimate of the total amount expended under this title to develop all measures of such type; and

(V) whether the measure would be electronically specified.

(iii) With respect to measures in development at the time of the report—

(I) the information described in clause (ii), if available; and

(II) a timeline for completion of the development of such measures.

(iv) An update on the progress in developing the types of measures described in paragraph (1)(A)(iii), including a description of issues affecting such progress.

(v) A list of quality topics and concepts that are being considered for development of measures and the

rationale for the selection of topics and concepts including their relationship to gap analyses.

(vi) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

(vii) Other information the Secretary determines to be appropriate.

(4) STAKEHOLDER INPUT.—With respect to measures applicable under the applicable provisions, the Secretary shall seek stakeholder input with respect to—

(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(A)(iii);

(B) prioritizing quality measure development to address such gaps; and

(C) other areas related to quality measure development determined appropriate by the Secretary.

(5) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2014 through 2018. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2021.

(t) PUBLIC REPORTING OF PERFORMANCE AND OTHER INFORMATION ON PHYSICIAN COMPARE.—

(1) IN GENERAL.—

(A) DEVELOPMENT.—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the program under this title under section 1866(j) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848.

(B) PLAN.—Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with paragraph (3), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the program under this title under section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this subsection are available, such information, to the extent practicable, shall include—

(i) measures collected under the Physician Quality Reporting Initiative;

(ii) an assessment of patient health outcomes and the functional status of patients;

(iii) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(iv) an assessment of efficiency;

(v) an assessment of patient experience and patient, caregiver, and family engagement;

(vi) an assessment of the safety, effectiveness, and timeliness of care; and

(vii) other information as determined appropriate by the Secretary.

(2) OTHER REQUIRED CONSIDERATIONS.—In developing and implementing the plan described in paragraph (1)(B), the Secretary shall, to the extent practicable, include—

(A) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(B) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(C) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(D) data that reflects the care provided to all patients seen by physicians, under both the program under this title and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(E) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(F) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this subsection; and

(G) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this subsection.

(3) ENSURING PATIENT PRIVACY.—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this subsection in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

(4) FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.—The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A, in selecting quality measures for use under this subsection.

(5) CONSIDERATION OF TRANSITION TO VALUE-BASED PURCHASING.—In developing the plan under paragraph (1)(B), the Secretary shall, as the Secretary determines appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under

section 131 of the Medicare Improvements for Patients and Providers Act of 2008.

(6) REPORT TO CONGRESS.—Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under paragraph (1)(A). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(7) EXPANSION.—At any time before the date on which the report is submitted under paragraph (6), the Secretary may expand (including expansion to other providers of services and suppliers under this title) the information made available on such website.

(8) FINANCIAL INCENTIVES TO ENCOURAGE CONSUMERS TO CHOOSE HIGH QUALITY PROVIDERS.—The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in clauses (i) through (vii) of paragraph (1)(B). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under this title as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under this title.

(9) PUBLIC AVAILABILITY OF ELIGIBLE PROFESSIONAL CLAIMS DATA.—

(A) IN GENERAL.—The Secretary shall make publicly available on Physician Compare the information described in subparagraph (B) with respect to eligible professionals.

(B) INFORMATION DESCRIBED.—The following information, with respect to an eligible professional, is described in this subparagraph:

(i) Information on the number of services furnished by the eligible professional, which may include information on the most frequent services furnished or groupings of services.

(ii) Information on submitted charges and payments for services under this part.

(iii) A unique identifier for the eligible professional that is available to the public, such as a national provider identifier.

(C) SEARCHABILITY.—The information made available under this paragraph shall be searchable by at least the following:

(i) The specialty or type of the eligible professional.

(ii) Characteristics of the services furnished, such as volume or groupings of services.

(iii) The location of the eligible professional.

(D) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that pub-

licized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

(E) IMPLEMENTATION.—

(i) INITIAL IMPLEMENTATION.—Physician Compare shall include the information described in subparagraph (B)—

(I) with respect to physicians, by not later than July 1, 2015; and

(II) with respect to other eligible professionals, by not later than July 1, 2016.

(ii) ANNUAL UPDATING.—The information made available under this paragraph shall be updated on Physician Compare not less frequently than on an annual basis.

(F) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for an eligible professional to review, and submit corrections for, the information to be made public with respect to the eligible professional under this paragraph prior to such information being made public.

(10) DEFINITIONS.—In this subsection:

(A) ELIGIBLE PROFESSIONAL.—The term "eligible professional" has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848.

(B) PHYSICIAN.—The term "physician" has the meaning given that term in section 1861(r).

(C) PHYSICIAN COMPARE.—The term "Physician Compare" means the Internet website developed under paragraph (1)(A) (or a successor website).

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PART E—MISCELLANEOUS PROVISIONS

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ADMINISTRATION

SEC. 1874. (a) * * *

* * * * * * *

(e) AVAILABILITY OF [MEDICARE] DATA.—

(1) * * *

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(3) DATA DESCRIBED.—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. *Effective July 1, 2014, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity.* The Secretary shall take such

actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts *or under titles XIX or XXI*.

(4) REQUIREMENTS.—

(A) FEE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited*, for periods prior to July 1, 2014,* into the Federal Supplementary Medical Insurance Trust Fund under section 1841*, and, beginning July 1, 2014, into the Centers for Medicare & Medicaid Services Program Management Account*.

* * * * * * *

(5) EXPANSION OF USES OF CLAIMS DATA BY QUALIFIED ENTITIES.—

(A) EXPANSION.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2014, notwithstanding paragraph (4)(B) (other than clause (iii) of such paragraph) and the second sentence of paragraph (4)(D), a qualified entity may, as determined appropriate by the Secretary, do any or all of the following:

(i)(I) Use the combined data described in paragraph (4)(B)(iii) to conduct analyses, other than for reports described in paragraph (4), for entities described in subparagraph (B) for non-public uses, as determined appropriate by the Secretary, such as for the purposes described in subclause (II).

(II) The purposes described in this subclause are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities (including developing new models of care), population health management, and disease monitoring, and the purposes described in subparagraph (C).

(ii) Provide or sell such analyses to entities described in subparagraph (B).

(iii) Provide entities described in clauses (i), (ii), (v), and (vi) of subparagraph (B) with access to the combined data described in paragraph (4)(B)(iii) through a qualified data enclave (as defined in subparagraph (F)) that is maintained by the qualified entity in order for entities described in such clauses to conduct analyses for non-public uses, such as for the purposes described in clause (i)(II).

(B) ENTITIES DESCRIBED.—For the purpose of subparagraph (A) clauses (i) and (ii), the entities described in this subparagraph are the following:

(i) A provider of services.

(ii) A supplier.

(iii) Subject to subparagraph (C), an employer (as defined in section 3(5) of the Employee Retirement Insurance Security Act of 1974).

(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act) that provides data under paragraph (4)(B)(iii).

(v) A medical society or hospital association.

(vi) Other entities approved by the Secretary (other than an employer (as so defined) and a health insurance issuer (as so defined)).

(C) LIMITATION WITH RESPECT TO EMPLOYERS.—Any analyses provided or sold under this paragraph to an employer (as so defined) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

(D) PROTECTION OF PATIENT IDENTIFICATION.—

(i) IN GENERAL.—Except as provided in clause (ii), an analysis provided or sold under this paragraph shall not contain information that individually identifies a patient.

(ii) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—An analysis that is provided or sold under this paragraph to a provider of services or supplier may contain data that individually identifies a patient of such provider or supplier but only with respect to items and services furnished by such provider or supplier to such patient.

(iii) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis under this paragraph to an entity described in subparagraph (B), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide an opportunity for such provider or supplier to review and submit corrections to such analysis.

(E) NO REDISCLOSURE.—An entity described in subparagraph (B) that is provided or sold an analysis under this paragraph shall not redisclose or make public such an analysis.

(F) REQUIREMENTS FOR A QUALIFIED DATA ENCLAVE.—

(i) DEFINITION.—For purposes of this paragraph, the term "qualified data enclave" means a data enclave that the Secretary determines meets the following:

(I) The data enclave is a web-based portal or comparable mechanism.

(II) Subject to the requirements described in clause (ii) and such other requirements as the Secretary may specify, the data enclave is capable of providing access to the combined data described in subparagraph (A)(iii).

(ii) ENCLAVE ACCESS REQUIREMENTS.—The requirements described in this clause are the following:

(I) A qualified data enclave shall preclude any entity that obtains access to the data from removing or extracting the data from such enclave.

(II) Subject to the succeeding sentence, the enclave shall preclude access to data that individ-

ually identifies a patient, including data on the patient's name and date of birth and such other data as the Secretary shall specify. Such data enclave may provide providers of services and suppliers with access to such individually identifiable patient data but only with respect to items and services furnished by such provider or supplier to such patient.

(III) Access to data in the enclave shall not be provided to any entity unless the qualified entity and the entity have entered into a data use agreement, the terms of which contain the requirements of this paragraph and such other terms the Secretary may specify.

(G) ANNUAL REPORTS.—Any qualified entity that provides or sells analyses pursuant to subparagraph (A)(ii) or provides access to a qualified data enclave pursuant to subparagraph (A)(iii) shall annually submit to the Secretary a report that includes—

(i) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses;

(ii) a description of the topics and purposes of such analyses;

(iii) information on the entities who obtained access to the qualified data enclave, the uses of the data, and the total amount of fees received for providing such access; and

(iv) other information determined appropriate by the Secretary.

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PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

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(n) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) * * *

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(3) MEANINGFUL EHR USER.—

(A) IN GENERAL.—For purposes of paragraph (1), an eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (b)(3)(B)(ix), for an EHR reporting period under such subsection for a fiscal year) if each of the following requirements are met:

(i) * * *

(ii) INFORMATION EXCHANGE.—The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and

standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination*, and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation referred to in section 1848(o)(2)(A)(ii)) that the hospital has not and will not take any deliberate action to limit or restrict the use, compatibility, or interoperability of the certified EHR technology*.

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PATIENT PROTECTION AND AFFORDABLE HEALTH CARE ACT

(Public Law 111-148)

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TITLE X—STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

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Subtitle C—Provisions Relating to Title III

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[SEC. 10331. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

[(a) IN GENERAL.—

[(1) DEVELOPMENT.—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w–4).

[(2) PLAN.—Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

[(A) measures collected under the Physician Quality Reporting Initiative;

[(B) an assessment of patient health outcomes and the functional status of patients;

[(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

[(D) an assessment of efficiency;

[(E) an assessment of patient experience and patient, caregiver, and family engagement;

[(F) an assessment of the safety, effectiveness, and timeliness of care; and

[(G) other information as determined appropriate by the Secretary.

[(b) OTHER REQUIRED CONSIDERATIONS.—In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

[(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

[(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

[(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

[(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

[(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

[(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and

[(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

[(c) ENSURING PATIENT PRIVACY.—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

[(d) FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.—The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014 of this Act, in selecting quality measures for use under this section.

[(e) CONSIDERATION OF TRANSITION TO VALUE-BASED PURCHASING.—In developing the plan under this subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, consider

the plan to transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

[(f) REPORT TO CONGRESS.—Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

[(g) EXPANSION.—At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other providers of services and suppliers under title XVIII of the Social Security Act) the information made available on such website.

[(h) FINANCIAL INCENTIVES TO ENCOURAGE CONSUMERS TO CHOOSE HIGH QUALITY PROVIDERS.—The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in subparagraphs (A) through (G) of subsection (a)(2). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under title XVIII of the Social Security Act as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under such title.

[(i) DEFINITIONS.—In this section:

[(1) ELIGIBLE PROFESSIONAL.—The term "eligible professional" has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

[(2) PHYSICIAN.—The term "physician" has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

[(3) PHYSICIAN COMPARE.—The term "Physician Compare" means the Internet website developed under subsection (a)(1).

[(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.]

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